Westinghouse Government Services Group

Welfare Benefits Plan Document and Summary Plan Description

Revised January 1, 2004

Introduction

Plan Document and Summary Plan Description

This is the Plan Document for the Westinghouse Government Services Group Welfare Benefits Plan (which we will simply call the "Plan"), as applicable to the employees and former employees listed in the section entitled "Who Is Covered By This Plan" on page 1. This is an "employee welfare benefit plan" under the federal Employee Retirement Income Security Act of 1974, as amended, ("ERISA") and, in part, a "cafeteria plan" under the Internal Revenue Code of 1986, as amended ("Code"). This document is also the Summary Plan Description ("SPD") for the Plan.

You will notice a number of capitalized words and phrases in this document. These words and phrases are generally defined in Appendix B.

Sponsor and Participating Employers

The Plan is sponsored by Westinghouse Government Services Group ("Westinghouse"), whose address for the purpose of employee benefits is 4350 Northern Pike, Room 217C, Monroeville, PA 15146.

Other related employers also participate in the Plan for the benefit of their employees. These other employers are called "Participating Employers", and they are listed in Appendix A, which is attached to this Plan. Whenever we say "the Employer" in this document, we mean Westinghouse or one of the other Participating Employers – whichever one employs (or last employed) you.

You will not be eligible to participate in the Plan if you do not work for an Employer listed in Appendix A. In addition, you will not be eligible to participate in the Plan if you work for an Excluded Unit.

Administrator

The Plan is administered by the Plan Administrator. Presently, the Plan Administrator is the Administrative Committee of Westinghouse Government Services Group, whose address is 4350 Northern Pike, Room 217C, Monroeville, PA 15146, and whose telephone number for the purpose of employee benefits is (412) 374-3995.

The Compensation and Benefits Staff of Westinghouse oversees the day-to-day administration of the Plan and can be reached at the address and telephone number listed above. For handling claims on a daily basis, the Administrative Committee has the discretionary authority to interpret and apply Plan terms and to make factual determinations in connection with its review of claims under the Plan. This discretionary authority is intended to include, but not be limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the Plan and, with respect to the self-insured programs, the determination of whether a person is entitled to benefits under the Plan, and if so, the level of benefits. The Administrative Committee reserves the authority to correct any errors that are made in its exercise of such discretionary authority including, without limiting any other remedy provided by law, seeking repayment of any amounts mistakenly paid to any person. The handling of claims and exercise of this discretionary authority has been delegated to the Compensation and Benefits Staff.

The Administrative Committee has the discretionary authority to perform a full and fair review, as required by ERISA, with respect to the self-insured programs, of each claim denial that is appealed by each claimant or his authorized representative. See Chapter 9 for a more detailed discussion of the appeal procedures for the Plan. The exercise of discretionary authority by the Administrative Committee or the Compensation and Benefits Staff shall be made on a uniform and nondiscriminatory basis among plan participants.

Effective Date

The Plan, as amended and restated in this document, is effective as of January 1, 2004. As of that date, this restated and amended Plan entirely supercedes and replaces all prior plans, programs and policies (if any) providing benefits of the same type as the benefits set forth in this Plan.

Plan Year

You will see references to the “Plan Year” in this document. The “Plan Year” is the calendar year.

The Features

This document contains a lot of information. No one expects you to sit down and read it through. Instead, you will probably consult it when a particular situation arises, such as when you make your choices at annual enrollment, when you need a particular benefit, or when there is a change in your employment situation. This document is designed to make it easy for you to find the information that you need. In this section, we will show you how the Plan is organized.

- **Chapter 1.** The first thing you care about is getting into the Plan. Chapter 1 describes who is eligible for the Plan and how to enroll.
- **Chapter 2.** Chapter 2 describes the flexible benefits feature, which constitutes a “cafeteria plan.” It lists which of the Plan’s coverages are included under the flexible benefits feature.

- **Chapter 3.** Chapter 3 explains the role of insurance with respect to some of the coverages included in the Plan.

- **Chapter 4.** The benefits that you are likely to use the most are the health care benefits. Chapter 4 describes the health care benefits one by one: medical coverage (which includes mental health and substance abuse treatment, prescription drug and vision coverage), dental coverage, the Health Care Spending Account, and the Employee Assistance Program.

- **Chapter 5.** Chapter 5 describes the short-term disability – called Accident & Sickness – and long-term disability benefit coverages that are available if you become disabled, either temporarily or permanently.

- **Chapter 6.** Chapter 6 describes the different types of benefits that may be available to provide support to your survivors if you should die. These include basic life insurance coverage, group universal life (GUL) (group universal life is not covered by ERISA, but we are listing it here for convenient reference), additional/supplemental life insurance coverage, and dependent life insurance coverage.

  Chapter 6 also describes the accidental death and dismemberment benefits that are available through insurance coverages: basic accidental death and dismemberment (AD&D), business travel accident, and personal accident for yourself and your family.

- **Chapter 7.** Chapter 7 describes other benefits. These include the Day Care Spending Account and Long-Term Care.

- **Chapter 8.** So far, the Plan will have given you an understanding of how to get into the Plan and how to take advantage of the different benefits when the time comes. Your last concern may be how changes in your employment situation effect your participation in the Plan and your benefit coverages.

  Chapter 8 has the answers. In Chapter 8, we examine various changes in your employment situation one by one and describe how each coverage is affected. The changes in employment situations include Leave of Absence, Total Disability, Voluntary Quit, Involuntary Termination, Furlough, Layoff, Permanent Job Separation, death and retirement.

- **Chapter 9.** When the time comes to take advantage of your benefit coverage, you need to know how to claim the benefit. And if your claim is denied, you need to know how to file an appeal. Chapter 9 provides all of that information.

- **Chapter 10.** Finally, Chapter 10 contains additional provisions, including technical and legal provisions that you may never need to refer to. At the very end, though, it does include the Statement of ERISA Rights, a statement prepared by the U.S. Department of Labor to alert you to your rights under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Table of Contents

Chapter 1 – Participation

Who is Covered by This Plan

This Plan covers all employees of the Employer, including employees covered by collective bargaining agreements, and certain other individuals, who are:

- Full-Time Employees, that is, employees who are regularly scheduled to work more than 32 hours per week for an Employer; and
- Part-Time Employees, that is, employees who are regularly scheduled to work between 24 and 32 hours per week for an Employer.

This Plan also covers Full-Time Employees and Part-Time Employees who are:

- on an approved Leave of Absence, including Total Disability; **
- on Furlough; ** or
- who are Laid-off.**

The Plan further provides coverage for former Full-Time Employees and Part-Time Employees:

- who are Permanently Separated; **
- who work for a Successor Employer; ** or
- who are Totally and Permanently Disabled.**

Finally, this Plan provides coverage for survivors of Full-Time Employees and Part-Time Employees. **

** Special provisions relating to coverage for these statuses are described in Chapter 8.

For the rest of this document, those persons are referred to as “eligible employees” or sometimes just “you.” This Plan does not cover Casual Employees, or employees in Excluded Units, which are employee groups specifically excluded from coverage under this Plan. Also, an individual hired through a temporary agency, a contract or any other arrangement who is not listed as an employee on the Employer's payroll records is not an eligible employee under the Plan. This rule applies even if a court or administrative agency determines that the individual is a “leased employee” under the Internal Revenue Code, or is an employee under common law or other legal standards. (See Appendix A for a list of Participating Employers and Appendix B for a definition of Casual Employee.)

A separate document constitutes the Plan for retirees and their dependents who are eligible for coverage under the retiree portion of the Plan. Together, both of these documents constitute the Plan.

Who Are Your Eligible Dependents

Participants in the Plan may also enroll their Eligible Dependents in those coverages that provide benefits to dependents. Your Eligible Dependents are defined in Appendix B.

In addition to these general eligibility rules for participation in the Plan, individual benefit coverages of the Plan may impose additional eligibility requirements to participate in that particular coverage. Any additional eligibility rules are described in the chapter regarding that particular coverage itself.

How To Enroll

Participation in the Plan does not begin until you actually enroll. If you are a new hire, you are eligible for all of your health and welfare benefits (all the benefits listed in this document, as applicable to your employment status) on the first of the month following 30 days of continuous employment, except for business travel accident insurance coverage, which begins on the first day of employment. This period from your date of hire until your participation begins is the Waiting Period.

Newly hired employees – including rehired employees and transferred employees – will receive an enrollment kit from the Westinghouse Benefits Center. The date by which you need to enroll – 31 days from the date the kit is generated - is printed on the Enrollment Notice included in the kit. You complete your enrollment and make changes to your benefit elections due to qualified family status changes via the *Your Benefits Resources*™ Web site, which you can access through *ConnectBenefits On-Line* at www.mybenefitsdirectory.com/westinghouse.

When Your Participation Begins

New Hires	If you complete your enrollment within 31 days of the date your enrollment notice is generated, generally your participation begins as of the date on which you became eligible. If you are not actively at work on your eligibility date for any reason unrelated to your health status, enrollment is postponed until you are actively at work. For Health Care and Day Care Spending Accounts, your participation begins with the first pay period beginning after you enroll. (Please note: If you do not enroll in Group Universal Life, Dependent Life Insurance Coverage, or Long-Term Disability Coverage within the initial 31-day enrollment period, you will be required to complete a statement of health in order to be enrolled for that coverage, even if you enroll in these coverages during the 30-day grace period listed below.) If you do not enroll within the initial 31-day period, you have an additional 30-day grace period during which to enroll. If you enroll during the grace period, your coverage will become effective on the first of the month after you enroll. If you do not enroll by the end of the 30-day grace period, you will be enrolled in Employer-provided coverages only - Basic Life and Accidental Death & Dismemberment (AD&D), Business Travel Accident, Accident & Sickness (A&S) Benefit Coverage, and the Employee Assistance Program (EAP). Please note: In order to assure compliance with various legal requirements, enrollment in the Plan is governed by the provisions set forth here in the Plan, regardless of the provisions of any insurance contract. That is to say, while the insurance carrier might be willing to accept you under the insurance contract at other times (as set forth in a booklet issued by the insurance carrier describing the insurance contract), this Plan alone governs when and how you may enroll in the Plan. There are several exceptions to the general rule about when your participation begins (listed below in this chart). In addition, there are a few exceptions to the general rule about when your participation begins that apply only to the health care coverage section of the Plan. These exceptions are listed on page 7 under “Changing Your Choices.” Your service as a Casual Employee (see definition of Casual Employee in Appendix B) will not count toward satisfying the Waiting Period.

Rehires	If you are involuntarily separated and are rehired within 12 months of separation, and you complete your enrollment within 31 days of the date your enrollment notice is generated, your participation generally begins as of the date on which you became eligible. You are eligible for coverage on the first day of work, if you previously met the Waiting Period. Otherwise, you are eligible for coverage on the 1st of the month after 30 days of continuous employment from your rehire date. For Health Care and Day Care Spending Accounts, if you complete your enrollment within the initial 31-day period, your participation begins with the first pay period beginning after you enroll. (Please note: If you do not enroll in Group Universal Life, Dependent Life Insurance Coverage, or Long-Term Disability Coverage within the initial 31-day enrollment period, you will be required to complete a statement of health in order to be enrolled for that coverage, even if you enroll in these coverages during the 30-day grace period listed below.) If you voluntarily quit, are rehired, and complete your enrollment within 31 days of the date your enrollment notice is generated, your participation generally begins as of the date on which you became eligible. If your rehire date is within 30 days of your termination of employment, you are eligible for coverage effective on the first day of your return to work, if you previously met the Waiting Period. If your rehire date is more than 30 days from the date of termination, you are eligible for coverage on the 1st of the month after 30 days of continuous employment from your rehire date. For Health Care and Day Care Spending Accounts, if you complete your enrollment within the initial 31-day period, your participation begins with the first pay period beginning after you enroll. (Please note: If you do not enroll in Group Universal Life, Dependent Life Insurance Coverage, or Long-Term Disability Coverage within the initial 31-day enrollment period, you will be required to complete a statement of health in order to be enrolled for that coverage, even if you enroll in these coverages during the 30-day grace period listed below.) If you are rehired after an Involuntary Separation or voluntary quit, and you do not enroll within the initial 31-day period, you have an additional 30-day grace period during which to enroll. If you enroll during the grace period, your coverage will become effective on the first of the month after you enroll. If you do not enroll by the end of the 30-day grace period, you will be enrolled in Employer-provided coverages only - Basic Life and Accidental Death & Dismemberment (AD&D), Business Travel Accident, Accident & Sickness (A&S) Benefit Coverage, and the Employee Assistance Program (EAP). If you are a retiree and are rehired as an active employee, you will receive the benefits in effect at that time for active employees and cannot continue to receive retiree benefits. If you subsequently Retire again, you will receive the retiree benefits in effect at the time of your subsequent retirement.
Transfers	If you transfer to an Employer from an Excluded Unit or from a Parent Company, and you complete your enrollment within 31 days of the date your enrollment notice is generated, your participation generally begins as of the date on which you became eligible. You are eligible for coverage on the first day of work with the Employer if you had previously met the Waiting Period with the Excluded Unit or the Parent Company. For Health Care and Day Care Spending Accounts, if you complete your enrollment within the initial 31-day period, your participation begins with the first pay period beginning after you enroll. (Please note: If you do not enroll in Group Universal Life, Dependent Life Insurance Coverage, or Long-Term Disability Coverage within the initial 31-day enrollment period, you will be required to complete a statement of health in order to be enrolled for that coverage, even if you enroll in these coverages during the 30-day grace period listed below.) If you do not enroll within the initial 31-day period, you have an additional 30-day grace period during which to enroll. If you enroll during the grace period, your coverage will become effective on the first of the month after you enroll. If you do not enroll by the end of the 30-day grace period, you will be enrolled in Employer-provided coverages only - Basic Life and Accidental Death & Dismemberment (AD&D), Business Travel Accident, Accident & Sickness (A&S) Benefit Coverage, and the Employee Assistance Program (EAP).

When Your Participation Ends

Your participation in the Plan ordinarily ends when you are no longer actively employed by the Employer, you otherwise cease to meet the eligibility requirements, or you cease to make the required contributions for coverage. Cessation of active employment includes any separation from active work (for any reason, whether voluntary or involuntary, permanent or temporary), except that cessation of active employment does not include vacation or holidays. If a particular coverage includes any additional eligibility requirements, your participation in that coverage ordinarily ends when you cease to meet the eligibility requirements for that coverage.

We say “ordinarily,” because there are several possible exceptions. These exceptions are listed in Chapter 8 of this document. Any such specific rule takes precedence over the general rule described here.

If you are a retiree who is covered by the Plan and are rehired as an active employee by any of the Participating Employers under the Plan, or by any participating employers under the Westinghouse Electric Company Welfare Benefits Plan, you will receive the benefits in effect at that time for active employees and cannot continue to receive retiree benefits. If you subsequently Retire directly from active service as a Full-Time Employee with a Participating Employer again, you will receive the retiree benefits in effect at the time of your subsequent retirement, if any.

When Your Dependent's Participation Ends

Of course, your dependents cease to participate in the Plan if you cease to participate in the Plan. But a dependent's participation also ceases if the dependent no longer meets the eligibility requirements for dependents. Here are some specific rules for dependents:

- Coverage for a spouse ceases on the first day on which the individual ceases to qualify as an eligible dependent under the Plan.
- Coverage for an eligible dependent child ceases on the child's 21st birthday unless the child is enrolled as a full-time student in a recognized course of study or training, and otherwise meets the definition of an eligible dependent. In addition, for a child who is a full-time student –
    - Coverage ceases on the dependent child's 25th birthday.
    - Coverage ceases on June 1 of any year if you do not certify a dependent age 21 or over as a full-time student during the annual full-time student certification solicitation for that year.
    - If earlier, coverage ceases on the first day on which the dependent is no longer a full-time student, including graduation or other loss of full-time student status before the child's 25th birthday.

Choices Available When Participation Ends

When participation ends, the following options may be available to you, your spouse or your dependent children: Company Continuation, COBRA and conversion. These alternatives are described in Chapter 4 (in the “Continued Coverage Under COBRA” section on page 30) and in Chapter 8, “How Changes in Your Employment Situation Affect Your Participation in Your Benefit Coverages” on page 52.

Certificate of Creditable Coverage

If you leave the Employer and join the group health plan of a new employer, and the group health plan of the new employer contains an exclusion or limitation for pre-existing conditions for some period of time, you may be entitled to credit under the plan of the new employer for the time when you were covered by the health care coverage of this Plan. The Plan Administrator is responsible for giving you a certification of your "creditable coverage":

- when you cease to be covered under the health care coverage of the Plan (ignoring continued coverage under COBRA), and
- if you choose continued coverage under COBRA, when your COBRA coverage ends, and
- thereafter, upon request, for up to two years.

"Creditable coverage" includes waiting periods and affiliation periods (both as defined in the law) and the period of your continued coverage under COBRA (if any).

Chapter 2 – The Flexible Benefits Feature

Introduction

The flexible benefits feature of the Plan offers you the opportunity to choose among a variety of benefits that are offered, as well as choose different levels of coverage or different coverage options in some benefits. The following coverages of the Plan are included in the flexible benefits feature:

- medical coverage (including mental health and substance abuse treatment, prescription drug and vision coverage),
- dental coverage,
- additional/supplemental life insurance coverage,
- personal accident insurance coverage for yourself,
- the Health Care Spending Account, and
- the Day Care Spending Account.

The flexible benefits feature constitutes a "cafeteria plan" under section 125 of the Internal Revenue Code.

Each year, at annual enrollment, you can go on-line to the *Your Benefits Resources*™ Web site, which you can access through *ConnectBenefits On-Line* at www.mybenefitsdirectory.com/westinghouse, to see the benefits included in the flexible benefits feature and the other choices that are available to you, as well as the cost to you for each option. Under the Westinghouse benefits program, each benefit option has a price. Prices vary depending on your choice of Coverage Category and in some cases, your pay or age. If you are an active Full-Time Employee and you elect to opt out of medical coverage under the Plan and to be covered as a dependent under your spouse's coverage, you will not be covered by a medical coverage option under the Plan, but you will receive additional taxable income in your paycheck; this option is not available, however, if you are an active Full-Time Employee and you are married to another Full-Time Employee or Part-Time Employee.

If you are receiving pay, your contributions for medical, dental, additional/supplemental life insurance, personal accident insurance coverage for yourself and the Health Care and Day Care Spending Accounts are taken from your pay on a pre-tax basis. Contributions for group universal life, personal accident insurance coverage for your family, dependent life insurance coverage and long-term disability benefit coverage are taken from your pay on an after-tax basis. The advantage of Pre-Tax Contributions is that you are not subject to federal income tax or Social Security tax (FICA) on the amount of any pay reduction.

Please note: Under the current Social Security system, when you Retire and claim Social Security benefits, your benefits are based on the earnings on which you paid Social Security taxes. Using this Plan to reduce the earnings on which you pay Social Security taxes may reduce the earnings that the Social Security Administration uses to compute your Social Security benefits. Most people feel that saving FICA taxes now is worth much more than the potential reduction in Social Security benefits at retirement, but we want you to be aware of the situation so that you can make up your own mind.

Making Your Choices

The choices you make during annual enrollment last for a whole Plan Year at a time. (In the year when you first sign up, they last for the rest of the Plan Year.) This means, for example, that if you leave the Plan and come back before the end of the same Plan Year, you cannot change the choices that you made during annual enrollment unless you have one of the special circumstances described in the following section. If you leave the Plan and come back after the end of that Plan Year, a new enrollment will be necessary.

Reviewing Your Confirmation Statement

After you make your choices during annual enrollment, and following any changes that you make to your choices as a result of a change in status (as discussed below), you should review your Confirmation Statement through the *Your Benefits Resources*™ Web site, which you can access through *ConnectBenefits On-Line* at www.mybenefitsdirectory.com/westinghouse. The Confirmation Statement is a report of your health and welfare benefit elections under the Plan that shows the benefit options you elected and the cost for those elections.

You should review the Confirmation Statement after annual enrollment to be sure that your choices were recorded correctly, as the elections shown on your Confirmation Statement will be in effect until the next Plan Year, unless you have a change in status, as described below.

Similarly, you should review the Confirmation Statement after you make a change to your elections as a result of a change in status, as the new election will be in effect until the next Plan Year, unless you have another change of status in the same year.

Changing Your Choices

Because of the tax benefits to you, you can not change your choices in the middle of a Plan Year except in one of the circumstances listed below. In addition, any change that you make must be on account of and consistent with the change of circumstance. **You may not change your elections under the Health Care Spending Account during a Plan Year, even if you satisfy one of the circumstances listed below.**

The Compensation and Benefits Staff has the authority to determine whether any change you make in your elections is consistent with your change of circumstance. In addition, the Compensation and Benefits Staff has the authority to request evidence, such as a copy of a marriage certificate or divorce order, to establish that you, your spouse or dependent has experienced a change in status.

Changes in health plan enrollment

You may change your health coverage choices in accordance with your special enrollment rights:

- If you choose not to enroll in health care coverage under the Plan when you are first hired because you have other health coverage (for example, COBRA coverage from a previous employer or coverage as a dependent under your spouse's health insurance), you may enroll in the Plan's health care coverage whenever that other coverage ends (for example, you exhaust all available COBRA coverage or you are divorced) or if Employer contributions toward that other coverage are terminated. This exception applies separately to you, your spouse, and each dependent. To get special enrollment under this exception, you must go on-line to the *Your Benefits Resources*™ Web site, which you can access through *ConnectBenefits On-Line* at www.mybenefitsdirectory.com/westinghouse, to enroll within 31 days after the other coverage ends. Enrollment is effective on the date the other coverage ends.

- If you are eligible to participate in the Plan (regardless of whether you have actually enrolled) and you get married, then you or you and your new spouse may enroll if you are not enrolled by going on-line to the *Your Benefits Resources*™ Web site, which you can access through *ConnectBenefits On-Line* at www.mybenefitsdirectory.com/westinghouse and selecting the appropriate prompts. As long as you enroll or you were already enrolled, you may also enroll your new spouse and/or any new dependents. Enrollment is effective as of the date of the marriage if you enroll in the Plan's health care coverage at any time up to 31 days after your marriage.

- If you are eligible to participate in the Plan (regardless of whether you have actually enrolled) and a child is born to you or you adopt a child (including placement for adoption), then you (if you are not enrolled) or your spouse or the child, or any combination (if you are enrolled) may enroll in the Plan's health care coverage at any time up to 31 days after the birth, adoption or placement for adoption by going on-line to the *Your Benefits Resources*™ Web site, which you can access through *ConnectBenefits On-Line* at www.mybenefitsdirectory.com/westinghouse and selecting the appropriate prompts. The enrollment will take effect as of the date of the birth, adoption or placement for adoption.

  If you have a new child, even if you are enrolled in coverage for Employee Plus Two or More Dependents at the time of birth, adoption or placement for adoption, you must still enroll the child in the Plan's health care coverage within 31 days of the birth, adoption or placement for adoption for the child to have coverage as of the date of birth, adoption or placement for adoption.

If you do not go on-line to the *Your Benefits Resources*™ Web site to enroll in coverage within the 31-day period specified in one of the above paragraphs (i.e., following the loss of other coverage, marriage, birth or adoption of a child, or placement of a child for adoption), you will still have an additional 30-day period to call the Westinghouse Benefits Center to report the event and enroll in coverage. However, if you enroll during this additional 30-day period, your coverage will become effective on the first of the month after you call the Westinghouse Benefits Center at 1-800-890-3600, rather than on the effective date described above. Thus, for example, if you do not call to enroll a newborn child in coverage until the 45th day after the child's birth, coverage will be effective on the first of the month after you call the Westinghouse Benefits Center, rather than on the date of the child's birth.

Significant change in health coverage by third-party provider

If health coverage that you have chosen is provided by an independent, third-party provider and is significantly curtailed or ceases, you may choose instead any other, similar coverage that is available under the Plan (prospectively only, of course). For this purpose, withdrawal of a major hospital system from a PPO, or a substantial decrease in the number of doctors participating in the PPO, may be considered a significant curtailment of coverage. The Plan Administrator makes the determination whether health coverage is significantly curtailed. A significant change in health coverage does not entitle you to drop health coverage altogether. You must make any change to your health coverage by going on-line to the *Your Benefits Resources*™ Web site, which you can access through *ConnectBenefits On-Line* at www.mybenefitsdirectory.com/westinghouse, and selecting the appropriate prompts within 31 days of the significant change in coverage by the third-party provider. The change will be effective on the first day of the month after you contact the Westinghouse Benefits Center.

Change in cost of coverage for medical or dental coverage, or additional/supplemental life or personal accident insurance

If a third-party provider changes the cost of coverage for medical or dental coverage, or for additional/supplemental life or personal accident insurance, provided under the Plan, your choices will be adjusted automatically to reflect the change. The Plan Administrator may provide you with an opportunity to change your election if the Plan Administrator determines that an increase in your contribution toward the cost of one of these benefits is a significant change in your cost for that coverage.

Significant change in cost or coverage by a day care provider

If there is a significant change in the cost of a day care provider, and the provider is not your relative, you may adjust your election under the Day Care Spending Account to reflect the change. For example, if your child's caretaker increases the amount that he or she charges each day, you may change your election to reflect the increased cost, so long as the child care provider is not your relative.

Similarly, if there is a significant change in the availability of a day care provider -- regardless of whether the new provider is a family member -- you may revoke your previous election under the Day Care Spending Account and make a corresponding new election to reflect the change in the availability of the provider. For example, if you choose a new day care provider for your child and the new day care provider is more expensive than the previous day care provider, you may change your election to reflect the cost of the new child care provider.

Any change in election on account of a significant change in cost or coverage by a day care provider must be made by going online to the *Your Benefits Resources*™ Web site, which you can access through *ConnectBenefits On-Line* at www.mybenefitsdirectory.com/westinghouse, and select the appropriate prompts within 31 days after the change in cost or coverage.

Change in status (applicable to all coverage options except Health Care Spending Account)

You may change your choices with regard to medical or dental coverage, for the Day Care Spending Account, or for additional/supplemental life or personal accident insurance coverage only if (a) one of the following changes in status causes you, your spouse, or a dependent to gain or lose eligibility for coverage (under this Plan or a plan of the spouse's employer or dependent's employer), (b) the change in your choices is consistent with that change in eligibility, and (c) the change is made within a specified period from the date of the change in status.

By way of explanation, gaining or losing eligibility for a particular benefit package option will be considered gaining or losing eligibility for coverage. Becoming eligible for COBRA continuation coverage will be considered gaining eligibility for coverage. If the change of status is to become eligible for coverage under a plan of your spouse's employer or your dependent's employer, a change of election under our Plan is consistent with that change of status only if you actually elect coverage under the plan of your spouse's or dependent's employer.

By way of explanation, with regard to group term life insurance coverage only, the addition of a spouse or dependent will justify an increase in life insurance coverage, and the loss of a spouse or dependent will justify a reduction in life insurance coverage, even though the change in status does not cause the participant, spouse or dependent to gain or lose eligibility for life insurance coverage.

The changes in status are as follows:

- Your marital status legally changes, including marriage, divorce, legal separation (if it exists and constitutes a change in marital status under state law), annulment, or death of your spouse.
- The number of your dependents changes, including birth, adoption, placement for adoption, or death of a dependent.
- You, your spouse, or a dependent begins or ends employment. However, your spouse's or dependent's becoming eligible for Medicare does not constitute a significant change in the health coverage for this purpose, nor does exhaustion of limits of coverage under your spouse's or a dependent's plan.
- The hours of employment of you, your spouse, or a dependent change, including a switch between full-time and part-time status, or taking or returning from an unpaid Leave of Absence.
- A dependent becomes eligible or ceases to be eligible under the Plan, including attainment of a particular age or cessation of student status.
- There is a change in the place where you, your spouse, or a dependent works or resides.

Any change in election on account on one of the changes in status listed above must be made by going on-line to the *Your Benefits Resources*™ Web site, which you can access through *ConnectBenefits On-Line* at www.mybenefitsdirectory.com/westinghouse, and selecting the appropriate prompts within 31 days after the change in status occurs.

If your spouse or dependents will lose health coverage under the Plan as a result of a divorce, legal separation (if it exists and constitutes a change in marital status under state law), or annulment, or if your dependent ceases to be eligible under the Plan, you must go on-line to the *Your Benefits Resources*™ Web site, which you can access through *ConnectBenefits On-Line* at www.mybenefitsdirectory.com/westinghouse, and select the appropriate prompts to make your change immediately. Coverage for the person losing eligibility for coverage will terminate as of the date of the event. The person who would otherwise lose coverage may be eligible to elect COBRA continuation coverage, as described in Chapter 4, but the person will only be able to elect COBRA if you or the person losing coverage notify the Westinghouse Benefits Center within 60 days of the event causing the loss of coverage.

With respect to any other event listed above, if you go on-line to the *Your Benefits Resources*™ Web site to make your change within 31 days of the event, a change in election for health coverage will be effective as of the date of the event. If you do not go on-line to the *Your Benefits Resources*™ Web site to make your change within this initial 31-day period, you have an additional 30-day period to call the Westinghouse Benefits Center at 1-800-890-3600 to report the event and change your elections for health coverage. However, if you enroll or change coverage during this additional 30-day period, your new election will become effective on the first of the month after you call the Westinghouse Benefits Center, rather than on the date of the event.

Entitlement to Medicare or Medicaid

You may drop health coverage for an individual (whether yourself, your spouse, or a dependent) who enrolls in Medicare or Medicaid (other than the program of vaccinations for children).

You may terminate health coverage for an individual on account of such individual's enrollment in Medicare or Medicaid only if you make the change within 61 days of the person's enrollment in such coverage. If you go on-line to the *Your Benefits Resources*™ Web site, which you can access through *ConnectBenefits On-Line* at www.mybenefitsdirectory.com/westinghouse, to make the change within 31 days of the person's enrollment in Medicare or Medicaid, then the coverage change will be effective as of the date of the enrollment in Medicare or Medicaid. If you do not go on-line to the *Your Benefits Resources*™ Web site to make the change within this 31-day period, you will have an additional 30-day period to call to change the enrollment, although the change will become effective on the first of the month after you call, rather than as of the date of enrollment in Medicare or Medicaid. If you terminate health coverage for yourself, your spouse and dependents that are covered by your health coverage will also lose coverage. However, these individuals may be eligible for COBRA continuation coverage, as described later in Chapter 4.

Court orders

You may add health coverage for a child if required to do so by a judgment, decree or order resulting from divorce, legal separation, annulment or change in legal custody, including a Qualified Medical Child Support Order (QMCSO). Likewise, you may drop health coverage for a child if such an order requires your former spouse to provide coverage (rather than you). See Chapter 10 for additional information regarding QMCSOs.

Separation from service

If you separate from the service of the Employer, your elections under the cafeteria plan will be automatically revoked, except that you may elect COBRA continuation coverage for certain health coverage. The COBRA rules are described later in Chapter 4. If you return to service with the Employer and resume your participation in the cafeteria plan during the same Plan Year, your existing choices will remain in effect for the balance of that Plan Year (unless your election is changed for some other reason.) For example, if you have made a monthly dollar commitment to the Health Care Spending Account but do not choose to continue that coverage after separation from service with after-tax dollars under COBRA, and you return to service with the Employer during the same Plan Year, your election under the Health Care Spending Account will be reinstated for the balance of the Plan Year.

Failure to make required contributions

If you use the cafeteria feature to satisfy an employee contribution requirement with regard to any type of benefit but afterward you fail or refuse to satisfy the employee contribution requirement, regardless of whether you have separated from service, your choice will be considered canceled. You may not reinstate your choice (or make a new choice) for the balance of the Plan Year, except that, if the cancellation was due to a family or medical leave to which you were entitled under the federal Family and Medical Leave Act of 1993, then upon return to work you will be permitted to reinstate the same choices that were in effect when the leave began.

Chapter 3 – The Role of Insurance

Identifying Features With Insurance

Each section describing one of the features of the Plan starts with a paragraph with the heading "The Benefit Provided By This Feature." Sometimes, the benefit provided by a particular feature of the Plan is the payment of premiums on an insurance contract. If so, the following comments apply to that feature of the Plan.

Payment of Benefits

If the benefit provided by a particular feature of the Plan is the payment of premiums on an insurance contract, then that feature of the Plan does not pay your bills or pay you any cash benefits. Instead, that coverage of the Plan provides you with insurance coverage. If you incur Covered Expenses or become entitled to cash benefits, it is up to the insurance carrier to pay those expenses (or pay the cash benefits) to the extent provided in the insurance contract.

For any insured coverage, we recommend that you read the booklet and any other literature prepared by the insurance carrier, in which the insurance carrier describes the benefits under the insurance contract. The booklets prepared by the insurance carrier are included in Appendices G, H, M and O of this document.

Claims Regarding Eligibility For Insured Coverage Under the Plan

If the benefit provided by a particular feature of the Plan is the payment of premiums on an insurance contract, then claims regarding eligibility to participate in that coverage should be made to the Plan Administrator by following the procedures described in Chapter 9.

Claims For Benefits Under an Insurance Contract

Claims for reimbursement under an insurance contract are another matter. To make a claim under an insurance contract, you need to apply to the insurance carrier in the manner specified by the insurance carrier.

For any insured coverage, we recommend that you read the booklet and any other literature prepared by the insurance carrier, in which the insurance carrier describes the procedure for collecting benefits under the insurance contract, and that you follow the procedures set forth in that booklet for making claims to the insurance carrier under the insurance contract. If you're not sure whether an expense is covered by the insurance contract, you should ask the insurance carrier.

Any disputes over whether a benefit is payable under the insurance contract, how much the insurance carrier is contractually obligated to pay, or any other aspect of the employee's contractual rights under the insurance contract, is a matter primarily between the employee and the insurance carrier under the insurance contract. However, if you experience difficulty in resolving any disputes with the insurance carrier, the Plan Administrator may be able to assist you in resolving the dispute. You should contact the Plan Administrator at the address and telephone number listed in Appendix K concerning any disputes that you have with an insurance carrier.

Chapter 4 – Health Care Coverage

Medical Coverage

The Benefit Provided By This Feature

The benefit provided by this feature of the Plan is medical, mental health and substance abuse treatment, prescription drug and vision services.

Your Coverage

These medical coverage options provide coverage against the high cost of illness and injury and also provide certain Preventive Care benefits to help keep you well.

When you are initially hired, and then each year at annual enrollment, you decide which medical coverage option will apply to you and your dependents for the following Plan Year, which begins on January 1.

Special Eligibility Requirements

Part-Time Employees may only participate in the Standard PPO medical coverage option. Part-Time Employees may opt out of medical coverage, but will not receive the additional taxable income associated with the No Coverage option.

You may only cover your dependents for the same medical option as you choose for yourself. You cannot cover your dependents if you choose No Coverage for yourself.

Your Medical Coverage choices are:

For Full-Time Employees	For Part-Time Employees
No Coverage	No Coverage
Premium Preferred Provider Organization (PPO) Medical Coverage	Standard Preferred Provider Organization (PPO) Medical Coverage
Standard Preferred Provider Organization (PPO) Medical Coverage	
Comprehensive Out-of-Area Medical Coverage (only available to those without network access, as defined by the Network Administrator)	

If an active Full-Time Employee is married to another active Full-Time Employee, the employees can choose between each taking his/her own coverage, or the higher-paid employee can choose to cover his/her spouse as a dependent. If an employee chooses to be covered as a dependent of a Full-Time Employee, the employee opting out of his/her own medical coverage will not receive opt-out credits.

If you are a Part-Time Employee under this Plan, you may choose to have your own coverage, or you may choose to be covered as a dependent under a Full-Time Employee's or Part-Time Employee's medical coverage.

No Coverage Option

If you elect the No Coverage option for a year, you will not be covered by a medical option under the Plan and will therefore have no medical, mental health and substance abuse treatment, prescription drug, or vision coverage for that year. If you are an active Full-Time Employee (except if you are a Full-Time Employee married to another Full-Time Employee and you opt out of medical coverage to be covered as a dependent under your spouse's coverage), you will instead receive additional taxable income in an amount specified each year during annual enrollment. If you elect the No Coverage option for a year, you may subsequently elect coverage under a medical option for that year if you meet one of the circumstances described in Chapter 2.

Premium PPO and Standard PPO Medical Coverage Options

When you enroll in medical coverage through your Employer, you are automatically enrolled for mental health and substance abuse treatment, prescription drug and vision coverage. These are described later in this section.

A Preferred Provider Organization ("PPO") is a network of hospitals, doctors and other medical providers from whom you can choose each time you need a medical service. The amount you pay out-of-pocket for your health care depends on whether or not you use network providers. Network providers charge negotiated fees for services and the Plan makes higher payments for care received in the network. The medical coverage options make payments based upon the Allowance; therefore, you are responsible for paying amounts above the Allowance, if any, in addition to your Co-payment amount if you use an out-of-network provider. If you have questions about whether a provider participates in the network, contact the medical Network Administrator.

The Premium and Standard PPO medical options cover the same medical services. The differences between the options are in the Deductibles, Co-payment amounts, Out-of-Pocket Maximums, and contributions that apply to each option. The Covered Services and contributions for the Comprehensive Out-of-Area option are the same as the in-network Premium PPO medical option. You may enroll in the Comprehensive Out-of-Area option only if you live outside the PPO network service area, as determined by the Network Administrator. The details of the Premium and Standard PPO medical coverage options, including mental health and substance abuse treatment, prescription drug and vision coverage, are shown in Appendix C.

Covered and Non-Covered Medical Services

Each of the medical coverage options pays benefits only for medical conditions that are not Job-Related, are treated or prescribed by a doctor, and are Medically Necessary and Appropriate as determined by the Network Administrator.

Medical coverage does not pay for the services that are listed in Appendix E. The list of non-covered services, which is determined by the Network Administrator, is subject to change without advance notice. If you are uncertain whether a medical service is covered, please contact the Network Administrator.

For medical coverage details, refer to Appendix C.

Your Deductible

A Deductible is money you must spend on your own for Covered Expenses before the Plan pays benefits. Once you meet your Deductible, the Plan pays a certain percentage of Covered Expenses. The portion you must pay is your Co-payment. Appendix C shows the individual and family calendar year Deductibles and the Co-payments under each of the medical coverage options.

Some additional points to remember about how your Deductible works:

- Covered Expenses that are not subject to the Deductible are the $15 in-network office visit and $25 emergency visit Co-payment, in-network childhood immunization serum and in-network mammograms. However, if other services are performed during the office or emergency room visit, those services, such as X-rays or lab tests, are subject to Deductibles and Co-payments.

- Under any of the medical coverage options, you do not have to pay a Deductible for mental health and substance abuse treatment, prescription drug and vision coverage. However, any Co-payments you pay for these expenses do not count toward satisfying your medical coverage Deductible.

- In-network and out-of-network Deductibles are entirely separate. This means that the in-network Deductible will not count toward the out-of-network Deductible, and vice versa.

- One family member must meet the individual Deductible before the family Deductible can be met.

- If two or more covered family members are injured in the same accident, you only have to pay the individual (not family) Deductible. This Deductible then counts for all Covered Expenses due to the accident for the rest of that calendar year, for you and your covered dependents.

Your Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the most you will spend of your own money on Covered Expenses in a calendar year.

The individual Out-of-Pocket Maximum is the most that will apply to any one family member. Once you or a covered dependent reaches the medical individual Out-of-Pocket Maximum, the Plan pays 100% of that person's Covered Expenses for the rest of the calendar year, except for the $15 office visit Co-payment and the $25 emergency room Co-payment and your Co-payments under mental health and substance abuse treatment, prescription drug and vision coverage. Once your family Out-of-Pocket Maximum is reached, the Plan pays 100% of Covered Expenses for the rest of the calendar year for you and your covered dependents.

The Out-of-Pocket Maximum includes:

- Your Deductible, and

- What you spend in Co-payments when the Plan pays less than 100% of a Covered Expense.

The Out-of-Pocket Maximum does not include:

- The $15 in-network office visit Co-payment;

- The $25 emergency room visit Co-payment;

- Any amount over the specific limits of the Plan;

- Any amount above the Allowance and any amount above what is determined to be Medically Necessary and Appropriate;

- Any amounts you pay for mental health and substance abuse treatment, prescription drugs, and vision care; and

- Any amounts not payable because you did not follow the preadmission certification procedures as described in Appendix C.

Some additional points to remember about how your Out-of-Pocket Maximum works:

- In-network and out-of-network Out-of-Pocket Maximums are entirely separate. This means that the in-network Out-of-Pocket Maximum will not count toward the out-of-network Out-of-Pocket Maximum, and vice versa.
- One family member must meet the individual Out-of-Pocket Maximum before the family Out-of-Pocket Maximum can be met.

Lifetime Maximum Benefit

There is no Lifetime Maximum for in-network provisions of this coverage. However, there is a $300,000 Lifetime Maximum payable under the out-of-network provision of this coverage.

Mental Health and Substance Abuse Treatment, Prescription Drug and Vision Coverage

When you enroll in medical coverage through the Plan, you are automatically enrolled for mental health and substance abuse treatment, prescription drug and vision coverage through Network Administrators. If you are not enrolled in the Plan's medical coverage, you may not enroll for mental health and substance abuse treatment, prescription drug or vision coverage.

Mental Health and Substance Abuse Treatment Coverage

Mental health and substance abuse treatment coverage benefits are based on the following:

- The medical coverage option you select (Premium PPO, including Comprehensive Out-of-Area, or Standard PPO):
- Whether you pre-certify prior to receiving treatment; and
- Whether you use a network or an out-of-network provider.

To receive the highest benefit level, all inpatient and outpatient mental health treatment or evaluations and alcohol or drug rehabilitation treatment (including detoxification) or evaluation must be pre-certified by the Network Administrator before you receive care. If you do not pre-certify, your benefit will be severely reduced or denied.

Mental health and substance abuse treatment benefits are not subject to any Deductibles. Covered Services are payable up to the Allowance set by the Network Administrator. Any out-of-pocket expenses that you pay do not apply to your medical coverage Deductible or Out-of-Pocket Maximum.

Covered and Non-Covered Services

- Mental health and substance abuse treatment coverage does not pay for the services that are listed in Appendix E. The list of non-covered services, which is determined by the Network Administrator, is subject to change without advance notice. If you are uncertain whether a mental health and substance abuse treatment service is covered, please contact the Network Administrator.
- For mental health and substance abuse treatment coverage details, please refer to Appendix C.

Emergency Mental Health Care and Substance Abuse Treatment

- If, because of an emergency, you are admitted to a hospital or qualified mental health or substance abuse treatment facility, or receive outpatient mental health or substance abuse treatment, you, your doctor, or the facility must telephone the Network Administrator within 24 hours. Mental health or substance abuse treatment network professionals will review your case to determine how many days of treatment or treatment visits are needed. If the network reviewer determines that the treatment is not Medically Necessary and Appropriate, they will tell you and your doctor. Together, you can discuss other treatment.
- If a continued mental health or substance abuse stay or treatment is not justified after a normal or emergency admission, the Network Administrator will inform you, your doctor, and the treatment facility. The coverage pays benefits only up to 24 hours after you are notified unless your condition changes to show continued treatment is needed. Mental health or substance abuse treatment network professionals review any requests for a longer stay or treatment. You must pay for continued stays or treatment that the Network Administrator determines is not Medically Necessary and Appropriate.
- In some cases, the Network Administrator may recommend a transfer to an in-network provider for continued treatment. If you do not follow the transfer recommendation of the Network Administrator, your approved services will be paid at the out-of-network benefits level.
- If the Network Administrator is not notified within 24 hours of the mental health or substance abuse treatment inpatient admission or the initial mental health or substance abuse treatment or evaluation visit, benefits will be paid under the non-certified care provision. You will be responsible for all or part of your non-certified care if the Network Administrator determines that the care is not Medically Necessary and Appropriate.

Prescription Drug Coverage

Benefits will be paid for covered prescription drugs that are Medically Necessary and Appropriate for treatment of a sickness or injury that is not Job-Related. Covered prescription drugs must be prescribed in writing by a doctor and dispensed by a licensed pharmacist. Prescription drug coverage is the same regardless which medical coverage option you choose (Premium PPO, including Comprehensive Out-of-Area, or Standard PPO).

Prescription drug coverage is provided through a Network Administrator. The Plan only covers certain prescription drugs, and the drugs that are covered under the Plan are determined pursuant to a list maintained by the Network Administrator. The Network Administrator's pharmacies must be used to receive the highest benefit. You will reimbursed according to the benefit schedule in Appendix C.

Prescription drug coverage is not subject to any Deductibles. Any out-of-pocket expenses that you pay do not apply to your medical coverage Deductible or Out-of-Pocket Maximum.

Covered and Non-Covered Prescription Drugs and Services

- Prescription drug coverage does not pay for the services that are listed in Appendix E. The list of non-covered services, which is determined by the Network Administrator is subject to change without advance notice. If you are uncertain whether a prescription drug is covered, please contact the Network Administrator.
- For prescription drug coverage details, please refer to Appendix C.

Out-of-Network Retail Benefits

If you choose to go to an out-of-network retail pharmacy, you must pay the full cost of the prescription at the time of purchase. Then you must submit a claim form with the required information to the Network Administrator. You will be reimbursed according to the benefit schedule in Appendix C.

Vision Coverage

Vision exams, lenses and frames are included under vision coverage. Vision coverage is the same regardless which medical coverage option you choose (Premium PPO, including Comprehensive Out-of-Area, or Standard PPO).

Vision coverage is provided through a Network Administrator. If you choose to receive vision services from a participating provider, you will pay a flat Co-payment for vision exams and you will receive discounts on products and services. If you choose to go to an out-of-network provider, you must pay the full cost of services at the time of purchase. Then you must submit a claim with the required information to the Network Administrator. You will be reimbursed according to the benefit schedule in Appendix C.

Vision coverage is not subject to any Deductibles. Any out-of-pocket expenses that you pay do not apply to your medical coverage Deductible or Out-of-Pocket Maximum.

Covered and non-covered vision services

- Vision coverage does not pay for the services that are listed in Appendix E. The list of non-covered services, which is determined by the Network Administrator, is subject to change without advance notice. If you are uncertain whether a vision care service is covered, please contact the Network Administrator,
- For vision coverage details, please refer to Appendix C.

Case Management

Special cases of very serious (catastrophic) illness or injury may involve long-term medical treatment. In such cases, the case manager may recommend a treatment plan that would be cost effective and assist the patient in the recovery process. This is called case management.

A medical case management program could include payment for expenses not normally covered under the Plan. Such expenses would be payable if:

- The case manager decides that the expense is cost effective;
- The expense is not for custodial care or personal convenience; and
- The suggested treatment plan is agreed to by the patient and the patient's doctor.

For more information on medical case management, contact the medical Network Administrator at the phone number listed in Appendix K. The phone number can also be found on the back of your medical identification (ID) card. For mental health or substance abuse treatment case management information, contact the mental health and substance abuse treatment Network Administrator at the phone number listed in Appendix K.

Non-Duplication of Benefits Provision

This Plan may pay benefits if you also are eligible for benefits from another plan. This is called non-duplication of benefits. Your health care benefits under the Plan are coordinated with benefits from:

- Other employers' plans;
- Government plans; and
- Motor vehicle plans as required by law, including no-fault plans.

The Plan’s benefits combined with another plan's benefits will not exceed what this Plan would pay by itself.

Which plan pays first:

The plan covering the patient as an employee is primary over the plan covering the patient as a dependent, or as a retired or laid-off employee. When more than one plan pays benefits, the primary plan pays its normal benefits first. When the Plan is primary, it pays benefits without considering what the secondary plan might pay. The secondary plan then pays its benefits, if any are due. When the Plan pays second, it pays only the difference between the primary plan's payment and the Plan's normal benefits.

For dependent children:

When both parents' plans cover an eligible child, the plan of the parent who is actively employed is primary over the plan of the parent who is a retired or laid-off employee. In all other situations, the plan of the parent whose birthday comes first in the calendar year is primary.

If the parents are legally separated or divorced, the following guidelines apply:

- The plan of the parent with custody is primary and the other parent's plan is secondary. If the parent with custody remarries, the stepparent's plan is secondary. If the remarried parent with custody has no health care coverage, the stepparent's plan is primary. The plan of the natural parent without custody is secondary.
- However, the plan of the parent with legal financial responsibility for the dependent child is always primary. The plan of the other natural parent is secondary, and the plan of the stepparent, if any, pays third.
- If none of the above situations apply, the plan that has covered the patient the longest is primary.

For those eligible for Medicare:

For employees and their dependents eligible for Medicare, the Plan is usually primary if the spouse is not covered by another employer's plan.

For those eligible for Medicare because of end-stage renal disease, the Plan is primary only for the first 30 months. After the first 30 months, the Plan is secondary to Medicare.

The Plan shall be considered secondary and Medicare primary for disabled employees who meet all of the following conditions:

- The employee is no longer working due to a disability;
- The employee qualifies for Social Security because of a disability;
- The employee is eligible for Medicare;
- The employee does not have other group health plan coverage as a dependent of an active employee; and
- The employee has received disability benefits from the Plan for six months.

Once it has been determined that an employee meets the above criteria, any payments made by the Plan will be calculated as if the employee were enrolled in Medicare, regardless of the actual enrollment status.

For maximum benefit:

A claim should be filed promptly with the Plan and the other plan to receive the maximum benefits. The person making claim under the Plan must supply all the information needed to help administer the non-duplication of benefits provisions.

Subrogation Rights

Any medical expenses for which a third party is responsible - as a result of the third's party's actions or omissions - are not covered by the Plan. For example, if a participant is injured in an automobile accident and the other driver is responsible for the participant's medical expenses related to that accident, those expenses are **not** covered by the Plan. However, the Plan and Network Administrator will "advance" payments to the participant or Eligible Dependent by paying benefits as otherwise provided under the terms of the Plan, subject to the terms and conditions of this section. Advances will be made and need not be reimbursed until it is determined whether a third party is responsible to pay for the services and supplies provided by the Plan or Network Administrator.

The Network Administrator will provide you with a questionnaire if the Network Administrator believes that a third party may be responsible for your medical expenses. You should contact the Network Administrator if you believe that a third party may be responsible for your medical expenses and you do not receive a questionnaire from the Network Administrator; in such a case, the Network Administrator will provide you with a questionnaire. **You must complete and return the questionnaire to the Network Administrator by the date specified by the Network Administrator.**

If you indicate on the questionnaire that a third party may be responsible for your medical expenses, the Network Administrator may ask you to complete and return a reimbursement and subrogation agreement. You must complete and return the reimbursement and subrogation agreement by the date specified by the Network Administrator or its delegate. The reimbursement and subrogation agreement will provide, among other things, that:

- the participant or Eligible Dependent agrees to reimburse the Plan and/or Network Administrator out of any amounts paid or payable by any third party or by the third party's insurer to the extent of the entire amount advanced by the Plan and/or Network Administrator;

- the Plan and Network Administrator has a priority lien against the proceeds of any settlement, judgment, arbitration or recovery made by the participant or Eligible Dependent to assure that reimbursement is properly made;

- the Plan or Network Administrator is subrogated to each participant's or Eligible Dependent's right of recovery from a third party or a third party's insurer to the extent that the Plan or Network Administrator advances any benefit payments (in other words, the Plan stands in the shoes of the participant or Eligible Dependent to the extent of the advance);

- the participant and/or Eligible Dependent agree to do nothing to waive, compromise, diminish, release or otherwise prejudice the Plan's rights; and

- the participant and/or Eligible Dependent will notify the Plan Administrator and consult with the Network Administrator before commencing or settling any lawsuit or administrative proceeding with respect to the third-party's liability.

If any participant or Eligible Dependent does not execute the reimbursement and subrogation agreement for any reason, that failure to sign the agreement will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's reimbursement and/or subrogation rights.

In any action where the Plan or Network Administration makes an advance of benefits, the Plan Administrator, or the Network Administrator on behalf of the Plan Administrator, may intervene in any claim, legal action or administrative proceeding started by a participant or Eligible Dependent against the

third party or third party's insurer (or any other entity that is in any way responsible for the injury or illness) with respect to the third party's acts or omissions that caused or contributed to the participant's or Eligible Dependent's injury or illness. This expressly includes, to the extent permitted by state law, any claims, legal actions or administrative proceedings started by a participant or Eligible Dependent regarding the participant's or Eligible Dependent's own underinsured or uninsured automobile insurance coverage. The participant or Eligible Dependent must keep the Plan Administrator informed of all material developments with respect to these claims, actions or proceedings.

Similarly, the Plan Administrator, or the Network Administrator on behalf of the Plan Administrator, may at its discretion, start any legal action or administrative proceeding that it deems necessary to protect the Plan's or Network Administrator's right to recover any amount advanced in accordance with this section. The Plan may further try to settle the action or proceeding in the name of, and with the cooperation of, the participant and/or Eligible Dependent. However, in doing so, the Plan, Plan Administrator or Network Administrator will not provide legal representation to the participant or Eligible Dependent to the extent that the person's damages exceed the amount advanced by the Plan.

If a participant or Eligible Dependent fails to reimburse the Plan or Network Administrator as required by this section, or does not provide the necessary cooperation to allow the Plan to exercise its rights to reimbursement or subrogation, the Plan will not cover benefits that would otherwise be payable under the Plan for the participant or Eligible Dependent, up to the dollar limit of benefits that should have been reimbursed to the Plan under this section. The Plan is a self-insured employee welfare benefit plan established pursuant to ERISA, and ERISA preempts any state law that purports to restrict the Plan's rights to subrogation and reimbursement.

Payment of Benefits

Claims for medical benefits must be submitted by December 31 of the calendar year following the calendar year in which the claim was incurred to be eligible for reimbursement under the Plan. Please refer to Chapter 9 for information about how to file a claim for medical benefits.

The contracts for the medical portion of this Plan are so-called administrative services only ("ASO") contracts. Under these contracts, the administrative service providers administer the benefits for a fee, but the benefits costs are paid directly from the general assets of the Employer. Because the administrative service providers do not assume financial responsibility for the benefits, these are not technically "insurance contracts."

Participant Contributions

The Employer will deduct any required contribution for medical coverage from your pay on a pre-tax basis. If you have no pay, you will be billed for your contribution. All participant contributions will be applied to provide benefits before any Employer contributions are made. If your contributions are not received for any reason within 30 days of the date they are due, medical coverage for yourself and your Eligible Dependents will be discontinued. A chart showing your contribution toward the cost of the medical coverage is included in Appendix J.

Dental Coverage

The Benefit Provided By This Feature

The benefit provided by this feature is dental services.

Your Coverage

Dental coverage helps pay dental bills for you and your family, and is designed to encourage good dental care.

Each year at annual enrollment, you decide which dental coverage option will apply to you and your dependents for the following Plan Year, which begins on January 1.

Special Eligibility Requirements

Part-Time Employees may only participate in the Standard PPO dental coverage option.

You may only cover your dependents for the same dental option as you choose for yourself. You cannot cover your dependents if you choose the No Coverage option for yourself.

If a Full-Time Employee is married to another Full-Time Employee, the employees can choose between each taking his/her own coverage, or the higher-paid employee can choose to cover his/her spouse as a dependent.

If you are a Part-Time Employee under this Plan, you may choose to have your own coverage, or you may choose to be covered as a dependent under a Full-Time Employee's or Part-Time Employee's dental coverage.

The benefits provided under the orthodontics provision of dental coverage are limited to eligible dependent children who are not yet age 19 when treatment begins.

Your Dental Coverage choices are:

For Full-Time Employees	For Part-Time Employees
No Coverage	No Coverage
Premium Preferred Provider Organization (PPO) Dental Coverage	Standard Preferred Provider Organization (PPO) Dental Coverage
Standard Preferred Provider Organization (PPO) Dental Coverage	

No Coverage Option

If you elect the No Coverage option for a year, you will not be covered by a dental option under the Plan and will therefore have no dental coverage for that year. If you elect the No Coverage option, you may subsequently elect coverage under a dental option if you meet one of the circumstances described in Chapter 2.

Premium PPO and Standard PPO Dental Coverage Options

Like the medical PPO options, you may receive care from providers in the network or you may go outside of the network. Network providers charge negotiated fees for services and the Plan makes higher payments for care received in the network. The dental coverage options make payments based upon the Allowance; therefore, you are responsible for paying amounts above the Allowance, if any, in addition to your Co-payment amount if you use an out-of-network provider.

The dental coverage pays only for treatment for a disease, defect, or accident that injures your teeth and is not Job-Related. Treatment must meet accepted dental standards and be provided by a licensed dentist.

Covered and Non-Covered Dental Services

Dental coverage does not pay for the services that are listed in Appendix F. The list of non-covered services, which is determined by the Network Administrator, is subject to change without notice. If you are uncertain whether a dental service is covered, please contact the Network Administrator.

For dental coverage details, refer to Appendix D.

Predetermination of Benefits

If you expect to have a dental service that may cost more than $300, you may request a predetermination of benefits. This allows you to get an estimate, before you have treatment, of what the Plan will pay and what you will have to pay on your own.

If you need a predetermination of benefits form, which is the same as the dental claim form, you can obtain it through the *Your Benefits Resources*™ Web site, the Network Administrator's Web site, or by calling the Network Administrator. Your dentist needs to complete the form and send it back to the Network Administrator. It is important to do this before your treatment begins, since the Network Administrator will then tell you which dental services are covered and how much it will pay. If your dentist changes the treatment plan, he or she should submit another predetermination of benefits form.

You do not have to use this program to receive benefits. However, the program helps you estimate what the coverage will pay and what you must pay yourself.

Benefits under the Plan, if any, will be paid after the services are actually performed and a claim form, if necessary, is submitted. Actual payments may differ because of changes in benefits provided under the terms of the Plan, a change in the services provided, other coverage, or a change in your coverage status.

Alternate Benefit

Alternate benefit refers to a situation in which more than one dental service or supply can treat the same dental problem. Sometimes, for example, either a crown or a filling could work as well. Alternate benefit identifies the different services that could treat a case. All services must meet acceptable dental standards.

If more than one service could treat your case equally well, the dental coverage pays benefits only for the less expensive treatment. If you wish, you may still have the more expensive treatment (a crown, for example, when a filling would do). In that case, you pay the difference between the two treatment options (for example, you would pay the difference between the dental coverage's payment for the filling and your dentist's charge for the crown).

Non-Duplication of Benefits and Subrogation Rights Provisions

See "Non-Duplication of Benefits Provision" on page 19 and "Subrogation Rights" on page 21. These provisions also apply to dental coverage.

Payment of Benefits

Claims for dental benefits must be submitted by December 31 of the calendar year following the calendar year in which the claim was incurred to be eligible for reimbursement under the Plan. Please refer to Chapter 9 for information about how to file a claim for dental benefits.

The contract for the dental portion of this Plan is a so-called administrative services only (ASO) contract. Under this contract, the administrative service provider administers the benefits for a fee, but the benefits costs are paid directly from the general assets of the Employer. Because the administrative service

provider does not assume financial responsibility for the benefits, this is not technically an “insurance contract.”

Participant Contributions

The Employer will deduct any required contribution for dental coverage from your pay on a pre-tax basis. If you have no pay, you will be billed for your contribution. All participant contributions will be applied to provide benefits before any Employer contributions are made. If your contributions are not received for any reason within 30 days of the date they are due, dental coverage for yourself and your Eligible Dependents will be discontinued. A chart showing your contribution toward the cost of the dental coverage is included in Appendix J.

Health Care Spending Account

The Benefit Provided By This Feature

The health care feature of the Plan buys coverage that pays for a variety of health care expenses (medical, mental health and substance abuse treatment, prescription drug, vision, and dental) expenses. But there are some expenses that the health care coverage feature of the Plan does not pay; instead, you pay them out of your pocket. If you take advantage of the Health Care Spending Account feature of the Plan, you can pay some of these expenses with dollars that are not subjected to federal income tax and Social Security tax. It also reduces your state and local income taxes in most states. Unfortunately, reimbursement of health care expenses under the Health Care Spending Account is still subject to state and local income tax in some jurisdictions, including Pennsylvania.

What's Good About Health Care Spending Accounts

When you pay health care expenses out of your pocket, you are paying with dollars on which you have paid federal income tax and Social Security tax (FICA). Federal income tax is at least 10% (more if you're in a higher income tax bracket) and Social Security taxes are currently 7.65%, which means that you have to earn at least $117.65 in order to pay $100 of these expenses out of your pocket.

This feature offers you the opportunity to pay these expenses before federal income tax and Social Security tax. To take the same example, if you choose to contribute $100 to a Health Care Spending Account, you will have $100 available to pay additional health care expenses - thus saving at least 17.65%. (However, these amounts may still be subject to state or local income tax where you live.)

How Health Care Spending Accounts Work

If you choose to have a Health Care Spending Account, either during your initial enrollment period as a new hire or during the annual enrollment period, that enrollment constitutes a contract between you and the Employer, in which you choose an alternative package of pay and benefits:

Here is an example that shows how the alternative package saves you taxes and increases your spendable income. (We picked $1,000 of health care reimbursement and assume that you are filing as a single taxpayer for this example. The actual effect will depend on the actual amount that you chose to put into your Health Care Spending Account, your income and your tax-filing status):

EXAMPLE	Regular Package	Alternative Package
Stated Pay	$20,000	$19,000
Federal Income Tax	$2,650	$2,500
FICA Tax	$1,530	$1,454

EXAMPLE	Regular Package	Alternative Package
Additional Health Costs	$1,000	Paid by this Plan
Spendable	$14,820	$15,046

- In the ordinary package of pay and benefits (that is, if you DO NOT choose to have a Health Care Spending Account under this feature of the Plan), you get a certain amount of pay and also get the regular health care coverage if you enroll (as described earlier). (This may be greater than your stated rate of pay if you are a Full-Time Employee who opted out of medical coverage, and therefore receive additional cash compensation.)

- In the alternative package of pay and benefits (that is, if you DO choose to have a Health Care Spending Account under this feature of the Plan), you get a package in which the pay is less but, in addition to the regular health care coverage, you get additional health care "reimbursement" under this feature. The amount of the reduction in the pay component (the amount that you put into your Health Care Spending Account for the Plan Year) is exactly equal to the additional reimbursement that is available under this feature of the Plan.

It seems a little artificial, but this is how the law works: in the alternative package of pay and benefits, the amounts that used to be after-tax payments by the employee are now Employer payments. Since they are Employer payments, they are not subject to federal income tax or FICA.

What Kinds of Expenses Can Be Reimbursed

Using this feature of the Plan, you can be reimbursed for expenses that you incur for medical care (as defined in section 213(d) of the Internal Revenue Code, except for long-term care, which is not reimbursable under this feature of the Plan) of yourself, your spouse and your dependents (as defined in section 152 of the Internal Revenue Code) that aren't reimbursed from any health plan that you may be covered under or by any other health coverage that you have, and that have not been and will not be deducted on your federal income tax return. However, premiums that you, your spouse or eligible dependent pay for coverage under a health plan are not reimbursable expenses under the Health Care Spending Account. In addition, please note that medical and dental services performed, and prescription drugs taken, solely for cosmetic reasons are not reimbursable by the Health Care Spending Account.

Medical expenses that can be covered by this feature of the Plan include:

- Expenses incurred for medical care for you or your Eligible Dependent that aren't covered at all by the health care coverage feature of the Plan. Depending on what the health care coverage covers from time to time, this might include, for example, chiropractic care, acupuncture or over-the-counter non-prescription medicines for you or your Eligible Dependents; and

- Expenses that are covered by the health care coverage feature of the Plan but not in full. This means you can use this feature of the Plan to cover Deductibles, Co-payments, and expenses that are beyond some dollar limit in the coverage that you get from the Plan.

The IRS publishes a helpful guide to deductible expenses called Publication 502-Medical and Dental Expenses. You can get a free copy from the IRS by calling (800) TAX-FORM. You can also obtain Publication 502 on the Internet at www.irs.gov. Please note, however, that this publication only describes deductible expenses. Expenses for over-the-counter medications (such as antacids, allergy medicines, pain relievers and cold medications) are not described in IRS Publication 502 because they are not deductible; they are, however, eligible for reimbursement under the Health Care Spending Account.

You can also contact the Spending Account Administrator if you have any questions about whether an expense is reimbursable under the Health Care Spending Account.

How Much You Can Put Into Your Health Care Spending Account

You decide how much pay reduction (how much you would like to put into your Health Care Spending Account for the Plan Year) you would like to commit to health care reimbursement each year under this feature and that is the amount of additional health care expenses incurred during that year for which you are entitled to reimbursement. The only limitation is that the total annual amount cannot be less than $120 or exceed $5,000. If both you and your spouse are employed by the Employer, each of you can contribute the maximum amount to the Health Care Spending Account if you choose.

In deciding how much you would like, however, you will want to keep in mind this rule, which is imposed by the Internal Revenue Service:

If you don't incur health care expenses during a particular Plan Year that use up the full amount that you put into your Health Care Spending Account for that Plan Year, the unused balance is lost forever.

This rule is sometimes known as “use it or lose it,” which is an accurate description. Therefore, you should use this arrangement for expenses that are predictable - reasonably certain to occur and reasonably predictable in amount.

EXAMPLE: It may be easily predictable that your family will have expenses that exceed the Deductible amount under the health care coverage feature of this Plan every year. You could choose to have a Health Care Spending Account equal to the Deductible amount and then present those expenses for reimbursement under this feature of the Plan. That way, you can be reasonably certain that you will use up all of your entitlement under this feature of the Plan.

EXAMPLE: It may be fairly predictable in your family that at least one child will have an eye examination every year and need new eyeglasses. That's the kind of predictable expense for which you might want to be reimbursed from this feature of the Plan on a pre-tax basis.

During annual enrollment, if you don't change your Health Care Spending Account contribution amount, your current contribution amount will automatically be carried forward into the next Plan Year. If you want to change your current contribution amount for the next Plan Year, you must make your change during the annual enrollment period through the *Your Benefits Resources*™ Web site, which you can access through *ConnectBenefits On-Line* at www.mybenefitsdirectory.com/westinghouse.

When To Submit Expenses For Reimbursement

Because your enrollment applies for the entire Plan Year, it is easy to calculate what the total amount of health care reimbursement is expected to be for the year. That total amount is available to you at any time during the year. That means you may submit claims and have them paid in full (up to the total amount of your annual commitment to the Health Care Spending Account) during the Plan Year even though the full amount hasn't been taken out of your pay yet.

Submit all claims for reimbursement under the Health Care Spending Account as soon as possible, but in any event no later than 90 days after the end of the Plan Year. Pay reduction during a particular Plan

Year may be used to reimburse only expenses incurred during that Plan Year - not from earlier years or later years. And, as you know, any unused balance at the end of the year is lost forever. To avoid losing it, you must use it up with expenses incurred in that same Plan Year. That means expenses incurred in the following year cannot be paid out of the balance remaining at the end of the previous year.

Expenses are incurred when the health care is provided. This is true even if the physician does not bill you (or you don't pay) until later.

EXAMPLE: The doctor treats you on December 15 but doesn't send the bill until January 15. The expense was incurred in the first year (not the second year) and can only be reimbursed from the amount that you chose to put into your Health Care Spending Account for the first year.

The Spending Account Administrator will keep the books open for 90 days after the end of the Plan Year to allow you to submit claims for health care that was provided near the end of the year. But the books will be closed after 90 days, and any unused balance will be lost forever, as described above.

How To Submit Claims For Reimbursement

If you are entitled to reimbursement of a health care expense under this feature of the Plan, all you have to do is file a claim form with the Spending Account Administrator and substantiate the claim. If you need a copy of the claim form, you can obtain one through the *Your Benefits Resources*™ Web site, the Spending Account Administrator's Web site, or by calling the Spending Account Administrator. You can reach the *Your Benefits Resources*™ and the Spending Account Administrator's Web sites through *ConnectBenefits On-Line* at www.mybenefitsdirectory.com/westinghouse. You can also reach the Spending Account Administrator through Benefits Connection at 1-800-890-3600.

To substantiate the claim, you have to:

- present a bill showing what was done (or what was purchased), when, the amount charged, and proof of the amount that you paid, and
- sign a statement that the expense has not been reimbursed and is not reimbursable under any other health plan coverage.

In addition, you must provide a doctor's note to substantiate any claim for reimbursement of an over-the-counter medication that has both a medical and non-medical purpose. For example, you will need to include a doctor's note to establish that you are taking the product to treat a medical condition if you request reimbursement for a non-prescription acne cream that is also marketed by its manufacturer for its non-medical uses as a skin moisturizer, or for a non-prescription dandruff shampoo.

The Spending Account Administrator will review your claim within the time frames described in Chapter 9. If the claim is granted, the Spending Account Administrator will simply send you a check or, if you have submitted the proper form, will direct deposit your reimbursement into your designated account. If for some reason the claim is not granted, the Spending Account Administrator will notify you in writing after you filed the claim and point out the specific reasons and Plan provisions on which the denial is based, describe any additional information needed to complete the claim, and describe the appeal procedure. You may then appeal the denial of the claim, as set for in the denial letter and in Chapter 9.

When Your Employment Terminates

After you terminate employment, you may elect COBRA continuation coverage to continue to participate in the Health Care Spending Account for the rest of the year. If you elect to continue coverage in the

Health Care Spending Account pursuant to COBRA, and you pay the required COBRA premium, you can continue to get reimbursed for any amount up to the total annual Health Care Spending Account election amount that you elected before the start of the Plan Year (i.e., you can get reimbursed for eligible expenses incurred both before and after your termination of employment). This may be of no practical benefit to you because this COBRA coverage will have to be paid for with after-tax dollars, thereby removing the essential benefit of this feature of the Plan.

If you don't continue to participate in the Health Care Spending Account pursuant to COBRA continuation coverage after your termination of employment, then you can get reimbursement (up to the total annual Health Care Spending Account election amount that you chose) for eligible expenses incurred prior to the termination of your employment, but not for expenses incurred after that date.

Funding

This feature of the Plan is not funded or insured in any way. In return for your commitment of pay reduction to the Health Care Spending Account, what you get is the Employer's contractual obligation to reimburse you for health care expenses under this feature of the Plan. These additional reimbursements are paid from the Employer's general assets; they are not covered by any insurance contract and are not paid from any trust.

Employee Assistance Program ("EAP")

The Benefit Provided By This Feature

The benefit provided by this feature is the provision of confidential assessment and referral services provided through a group employee assistance program contract.

Your Coverage

The Employee Assistance Program ("EAP") is a confidential, professional assessment and referral service designed to help resolve personal problems, including parenting concerns, marital and family distress, emotional distress, alcohol and drug dependency, and legal and financial concerns. The EAP, as administered by the Network Administrator, is staffed nationally by EAP professionals with experience in providing assessment and referral services. Your participation in the EAP will be treated confidentially in accordance with all federal and state mandates.

The scope of the counseling services available from the Network Administrator is a maximum of five counseling sessions per Plan Year, in addition to unlimited telephone counseling. If additional counseling services are needed beyond the EAP, you may be referred to a qualified professional; in that situation, benefits will be provided in accordance with your mental health and substance abuse treatment coverage if you are enrolled in the Plan's medical coverage.

The EAP also includes an on-line service that provides access to a library of information related to work/life issues, such as parenting, elder care, stress, health and wellness. For more information, log onto *ConnectBenefits On-Line* at www.mybenefitsdirectory.com/westinghouse and select the appropriate prompts for the Employee Assistance Program, or you can log onto the on-line library directly on www.achievesolutions.net/westinghouse.

Monthly Payment of Premiums

Each month, the Employer pays the premium required under the contract for each covered employee.

Continued Coverage Under COBRA

The Benefit Provided By This Feature

COBRA is the acronym for the Consolidated Omnibus Budget Reconciliation Act of 1986 - a federal law that permits you to buy continued coverage under certain features of this Plan at group rates after your coverage would otherwise end. This feature of the Plan could help you if you terminate your employment and are in between jobs or have a waiting period with your new employer before you can begin receiving benefits.

COBRA applies separately to each "group health plan" within the meaning of the applicable regulation. That means COBRA applies separately to each feature of the Plan that has been described up to this point in the Plan, namely:

- Medical coverage (which includes mental health and substance abuse treatment, prescription drug, and vision coverage),
- Dental coverage,
- the Health Care Spending Account, and
- the Employee Assistance Program.

COBRA does not apply to any other features of this Plan. For example, COBRA doesn't apply to the life, accidental death and dismemberment, disability benefit coverage, and the Day Care Spending Account features of this Plan.

COBRA Administration

There are a number of different entities involved in the Plan's COBRA administration, as described in this Chapter.

- The Westinghouse Benefits Center is notified whenever a person has a "Qualifying Event" (as described below).
- COBRA is administered for the Plan by the COBRA Administrator (see Appendix B for the definition of the COBRA Administrator).
- The Plan Administrator has the final authority to determine matters regarding an individual's eligibility for COBRA coverage.

Please be certain that when you contact an entity regarding COBRA coverage that you are contacting the *correct* entity, as described below.

Qualifying Events

An event that entitles you (or your covered spouse or dependents) to buy continuation coverage under COBRA is known as a "qualifying event." Qualifying events are any of the events listed in the chart below if the event causes a loss of coverage under the group health plan.

Such an event is a qualifying event regardless of whether the loss of coverage occurs at the same time as the event or is delayed, as long as the loss of coverage will occur before the end of the maximum period of COBRA continuation coverage. The qualifying event is considered to occur when the event occurs, regardless of when coverage under the group health plan is lost. Unless otherwise stated in this Plan, any extension of coverage at the Employer's expense after such an event is considered voluntary relief from the COBRA premium requirement rather than a postponement of the qualifying event.

Termination of an employee's employment

Termination of an employee's employment, whether voluntary or involuntary and including quit and retirement, is a qualifying event for the employee, the employee's spouse if covered by the group health plan at the time of the event, and each dependent child covered by the group health plan at the time of the event, except that termination of employment by reason of gross misconduct of the employee shall not constitute a qualifying event for the employee, spouse or dependent children.

Reduction in the employee's hours

Reduction in the employee's hours for any reason, including, for example, Layoff, Leave of Absence, or reduction from full-time to part-time, is a qualifying event for the employee, the employee's spouse if covered by the group health plan at the time of the event, and each dependent child covered by the group health plan at the time of the event.

Since a leave to which an employee is entitled under the federal Family and Medical Leave Act does not result in loss of coverage under any group health plan, such a leave does not constitute a qualifying event. If the employee fails to return to employment at the end of such a leave, however, the failure to return will cause a loss of coverage and so the failure to return will constitute a qualifying event that occurs at the end of the leave.

Death

Death of the employee is a qualifying event for the employee's spouse if covered by the group health plan at the time of the event and for each dependent child covered by the group health plan at the time of the event.

Divorce or legal separation

Divorce or legal separation from the covered employee is a qualifying event for the employee's spouse if covered by the group health plan at the time of the event and for each dependent child covered by the group health plan at the time of the event.

The employee's becoming covered by Medicare

The employee's becoming covered by Medicare (that is, actual coverage, not mere eligibility) is a qualifying event for the employee's spouse if covered by the group health plan at the time of the event and for each dependent child covered by the group health plan at the time of the event.

A child's cessation of dependent status

A child's cessation of dependent status (for example, by attaining age 19) is a qualifying event for such dependent child if covered by the group health plan at the time of the event.

Who Is a Qualified Beneficiary

Each person who is entitled to continuation coverage by reason of a qualifying event is known as a “qualified beneficiary.” Only an individual who was actually covered by the group health plan at the time of the qualifying event can be a qualified beneficiary, except that children born to, or placed for adoption with, the employee during COBRA continuation coverage are considered qualified beneficiaries when born or placed for adoption.

There is an additional exception to the rule that an individual must be covered at the time of the qualifying event to be a qualified beneficiary. If a covered employee terminates coverage for his/her spouse solely in anticipation of a divorce or legal separation (for example, if an employee who is anticipating getting a divorce chooses, at annual enrollment, to discontinue medical coverage for his/her spouse for the following year), the Plan will make COBRA continuation coverage available to the ex-spouse as of the date of the divorce or legal separation, provided that the employee or ex-spouse notifies the Westinghouse Benefits Center within 60 days of the date of divorce or legal separation. Although the anticipatory elimination of coverage is disregarded in determining whether the divorce or legal separation causes a loss of coverage, no coverage will be made available for the period from when the employee terminated the coverage until the date of the divorce or legal separation.

A qualified beneficiary has the same rights as a similarly situated participant to add a spouse or dependent to his coverage at annual enrollment. See the discussion below under the heading "Coverage Received on COBRA." Please note, however, that a spouse or dependent added in this manner is not, and cannot become a qualified beneficiary, because the individual was not covered by the Plan at the time of the original qualifying event.

Notice to Westinghouse Benefits Center or COBRA Administrator

Affected parties must notify the Westinghouse Benefits Center of events affecting entitlement to COBRA continuation coverage as follows:

The Employer must notify the Westinghouse Benefits Center within 30 days after:

- the termination of employment of the employee,
- a reduction in the employee's hours that would result in a loss of coverage,
- the employee's becoming covered by Medicare, or
- the death of the employee.

The employee, spouse or affected dependent child, or a representative acting on such individual's behalf, must notify the Westinghouse Benefits Center within 60 days of:

- divorce or legal separation of the employee and spouse, or
- the dependent child's ceasing to be a dependent child.

You may notify the Westinghouse Benefits Center of this information through *ConnectBenefits On-Line* at www.mybenefitsdirectory.com/westinghouse. The spouse or child may notify the Westinghouse Benefits Center of this information by calling 1-800-890-3600, or by writing to the Westinghouse Benefits Center, 100 Half Day Road, P.O. Box 1478, Lincolnshire, IL 60069-1478.

Any qualified beneficiary who claims extended continuation coverage by reason of a disability extension (as described below) must notify the COBRA Administrator of the disability determination both within 60 days after receiving the Social Security determination that the individual is disabled and within the original 18-month period of continuation coverage. A qualified beneficiary receiving extended continuation coverage due to disability must notify the COBRA Administrator of any final determination that the person is no longer disabled and must do so within 30 days after receiving the determination.

Please note: Timely notice by the qualified beneficiary is a condition to entitlement to COBRA continuation coverage. If the qualified beneficiary fails to notify the COBRA Administrator within the deadlines set forth above, the qualified beneficiary is not entitled to COBRA continuation coverage.

Notice to Qualified Beneficiary

Within 14 days after receiving notice of a COBRA qualifying event, the COBRA Administrator will notify all qualified beneficiaries of their right to elect continuation coverage under COBRA. The determination of where qualified beneficiaries live will be governed by the latest address shown on the records of the COBRA Administrator.

- Where the qualified beneficiaries are the employee, spouse and/or dependent children, and all qualified beneficiaries reside at the same address, notice will be given by first-class mail addressed to the employee and spouse at that address. If, according to the COBRA Administrator's records, any qualified beneficiary lives at another address, a duplicate notice will be given by first-class mail addressed to that qualified beneficiary at the other address, except that notice to the spouse will be considered notice to all other qualified beneficiaries who reside with the spouse.

- Where the qualified beneficiaries are the spouse and/or dependent children, and, according to the COBRA Administrator's records, all qualified beneficiaries reside at the same address, notice will be given by first-class mail addressed to the spouse at that address. (Notice to the spouse is considered notice to all other qualified beneficiaries residing with the spouse.) If any qualified beneficiary lives at another address, according to the COBRA Administrator's records, a duplicate notice will be given by first-class mail addressed to that qualified beneficiary at the other address.

- Where the qualified beneficiary is only one or more dependent children, notice will be given by first-class mail addressed to each qualified beneficiary at the last known address, according to the COBRA Administrator's records, of that qualified beneficiary.

Election of Continuation Coverage

COBRA continuation is subject to the following election rules.

Timing

After receiving notice from the COBRA Administrator, each qualified beneficiary has 60 days to elect continued coverage under COBRA. (If the notice arrives before the date of the qualifying event, the qualified beneficiary will have 60 days from the date of the qualifying event to elect continued coverage under COBRA.)

Persons covered by an election

Election of continuation coverage is an individual election of each qualified beneficiary in accordance with the following rules:

- When an employee, spouse and dependent children are eligible for COBRA, if an employee elects continuation coverage for the employee, spouse and dependent children, the election is effective for the employee, spouse and dependent children; the spouse and dependent children do not have a separate election.
- When an employee, spouse and dependent children are eligible for COBRA, if an employee fails to elect continuation coverage for the spouse and/or dependent children (regardless of whether the employee elects continuation coverage for the employee), the spouse and/or dependent children are entitled to elect continuation coverage independently of the employee.
    - If a spouse elects continuation coverage for the spouse and/or dependent children, the election is effective for the spouse and/or dependent children; the dependent children do not have a separate election.
    - If neither the employee nor the spouse elects continuation coverage for a dependent child, the dependent child is entitled to elect continuation coverage independently.

Election of COBRA continuation coverage

Election of COBRA continuation coverage is made by returning to the COBRA Administrator such properly completed and signed forms as the COBRA Administrator may require. The COBRA election form may be returned at any time during the 60-day period described above.

Even if a qualified beneficiary returns the form during the 60-day period showing an election not to take COBRA continuation coverage, the qualified beneficiary may change his or her mind and elect continuation coverage by completing, signing and returning another form within the 60-day period described above, although in that case, the continuation coverage will be provided prospectively only (not retroactively to the qualifying event).

Though the form supplied by the COBRA Administrator is the preferred and usual method for making the election, any other method will be accepted that contains all of the information necessary to process the election, so long as the notice is timely submitted to the COBRA Administrator.

Please note: Failure to elect COBRA continuation coverage within the 60-day deadline described in this section constitutes a complete, final and permanent waiver of COBRA continuation coverage.

The coverage offered for election

The coverage offered for election shall be the same coverage that the qualified beneficiary had immediately before the qualifying event.

Upon valid election, coverage will be provided retroactively

Upon valid election, coverage will be provided retroactively to the date of the qualifying event, except that no claims will be paid for expenses incurred after the qualifying event unless and until the COBRA premium is timely paid (as discussed in the following section).

Payment for Continuation Coverage

COBRA continuation coverage is provided to the qualified beneficiary only if the qualified beneficiary pays the applicable premium for such coverage plus a 2% administrative charge. The applicable premium is the actual cost to the group health plan of providing the same coverage to participants and beneficiaries of the group health plan who have not suffered a qualifying event. (If the coverage is not insured, the applicable premium will be determined on an actuarial basis as provided in COBRA.) For example, if a spouse or dependent child elects COBRA continuation coverage and there is no employee coverage, so that the spouse or dependent child must be enrolled as if he or she were an employee, the applicable premium will be the premium for Employee-Only Coverage.

As an exception, qualified beneficiaries who are receiving an additional 11 months of continuation coverage due to disability must pay an amount equal to 150% of the applicable premium during those additional 11 months. As a further exception, where the qualifying event is the employee's absence due to service in the uniformed services of the United States (meeting the requirements of the federal Uniformed Services Employment and Reemployment Rights Act of 1994) and the employee performs such service for less than 31 days, the charge for COBRA coverage is limited to the employee contribution required of active employees.

Payment for all months up to and including the month in which the qualified beneficiary returns the election form to the COBRA Administrator must be made within 45 days after the election form is returned to the COBRA Administrator. Payment for months following the month in which the election form is returned to the COBRA Administrator must be made by the first of the month for which payment is made,

and in no event more than 30 days after the date the payment was due. You must pay the COBRA premium for the entire month of coverage; you may not prorate the COBRA premium for partial months of COBRA coverage.

Please note: It is the responsibility of the qualified beneficiary to make timely premium payments. The COBRA Administrator is not required to send bills or reminder notices.

Coverage Received on COBRA

A qualified beneficiary who timely elects and pays for COBRA continuation coverage receives the same coverage as similarly situated participants in the group health plan who have not suffered a qualifying event. For example, and not by way of limitation, changes in coverage, Deductibles, Co-payments and insurance carriers and Network Administrators applicable to participants who have not incurred a qualifying event will apply equally to each qualified beneficiary.

Each qualified beneficiary will also have the same rights as a similarly situated participant who has not incurred a qualifying event to participate in annual enrollment periods and make changes in his or her coverage, including, for example, the right to add a spouse or dependents. (Note, however, that a spouse or dependent added in this manner is not - and cannot become – a qualified beneficiary, because the individual was not covered by the Plan at the time of the original qualifying event.) As an additional example, if an individual is covered by a PPO option when the qualifying event occurs and elects COBRA under the PPO option but later moves out of the PPO's service area, the qualified beneficiary will be afforded the same opportunity as a participant in the PPO who has not suffered a qualifying event to elect alternative coverage.

Duration

Continuation coverage under COBRA will end at the expiration of the following time periods, unless terminated earlier as provided in this section:

Termination of employment or reduction in hours

The maximum period of continuation coverage is 18 months where the qualifying event is termination of employment or reduction in hours, except in the event of disability.

If an employee, spouse or dependent child is receiving continuation coverage by reason of the employee's termination of employment or reduction in hours (the “original qualifying event”), and the employee, spouse or dependent child is determined to have been disabled under Title II or XVI of the Social Security Act at any time during the first 60 days after the original qualifying event, then the maximum period of coverage for all such qualified beneficiaries will be extended to 29 months from the date of the original qualifying event. In the case of a qualified beneficiary who is a child born to a qualified beneficiary who is a former employee, or placed for adoption with a qualified beneficiary who is a former employee, during a period of COBRA continuation coverage, the period of the first 60 days of COBRA continuation coverage is measured from the date of birth or placement for adoption, rather than from the date of the original qualifying event. As described above, a qualified beneficiary who claims extended continuation coverage by reason of such a disability extension must notify the COBRA Administrator of the disability determination both within 60 days after receiving the Social Security determination that the individual is disabled and within the original 18-month period of continuation coverage. A qualified beneficiary receiving extended continuation coverage due to disability must notify the COBRA Administrator of any final determination that the person is no longer disabled within 30 days after receiving the determination.

Other qualifying events

The maximum period of continuation coverage is 36 months where the qualifying event is death, divorce or legal separation, Medicare coverage or cessation of dependent status.

Combination of qualifying events

If a spouse or dependent child is receiving continuation coverage by reason of the employee's termination of employment or reduction in hours (the “original qualifying event”) and the employee dies or the employee and the spouse are divorced or legally separated during the first 18 months of COBRA continuation coverage following the original qualifying event, then the maximum period of continuation coverage for the spouse and dependent child will be extended to 36 months from the date of the original qualifying event.

If a dependent child is receiving continuation coverage by reason of the employee's termination of employment or reduction in hours (the “original qualifying event”) but ceases to be a dependent child during the first 18 months of COBRA continuation coverage following the original qualifying event, then the maximum period of continuation coverage for the dependent child will be extended to 36 months from the date of the original qualifying event.

If a spouse or dependent child is receiving continuation coverage by reason of the employee's termination of employment or reduction in hours (the “original qualifying event”) but the employee became covered by Medicare less than 18 months before the original qualifying event, then the maximum period of continuation coverage for the spouse and dependent child will be extended to 36 months from the original qualifying event.

Termination before maximum period has expired

Continuation coverage for a qualified beneficiary will be terminated automatically and without notice to the qualified beneficiary if:

- the qualified beneficiary first becomes covered under any other group health plan after the date of the election of COBRA coverage, unless the other group health plan excludes or limits coverage for a pre-existing condition that the qualified beneficiary has and that exclusion or limitation is not satisfied by the qualified beneficiary’s previous coverage, or
- the qualified beneficiary first becomes covered by Medicare after the date of the election of COBRA coverage, or
- the individual is receiving extended coverage by reason of disability and ceases to be disabled, or
- payment of the required COBRA premium is not timely made, or
- the Employer ceases to provide any group health plan to any employee.

If the group health plan under which a qualified beneficiary is receiving COBRA continuation coverage terminates but the Employer continues to provide one or more group health plans, the qualified beneficiary will be afforded the same opportunity as participants with respect to whom a qualifying event has not occurred to participate in an alternative group health plan of the Employer.

Conversion Privilege

COBRA continuation coverage will not affect any right of any individual to conversion coverage under any insurance contract. For example, if an individual elects COBRA continuation coverage under a group health plan whose benefits are provided through an insurance contract that includes a conversion privilege at the conclusion of group coverage, the conversion privilege will be available when group coverage ends, i.e., at the conclusion of the COBRA continuation coverage. Likewise, an individual who

elects not to take COBRA continuation coverage may be entitled to a conversion policy at the time of the qualifying event.

Correction of Mistakes

If at any time it is determined that a mistake has been made with regard to administration of COBRA continuation coverage, regardless of whether the mistake is favorable or detrimental to the employee, spouse or dependent, all feasible steps shall be taken as soon as reasonably possible to correct the mistake by returning all affected parties to the position that they would have been in if the mistake had not occurred, including, if necessary, retroactive collection or refund of COBRA premiums and retroactive provision or denial of coverage.

Company Continuation

As further described in Chapter 8, in certain situations, your medical and/or dental benefits will automatically continue for a period of time after you would otherwise lose coverage. Similarly, if your spouse and/or dependent children are enrolled in medical and/or dental coverage under the Plan and you die, benefits for your surviving spouse and/or children will continue for a period of time if you met certain age and service requirements at the time of your death. The extension of these benefits is referred to as Company Health Care Continuation or just Company Continuation. The situations in which you or your spouse and dependent children will have a choice to elect Company Continuation are described in Chapter 8. You (or, in the event of your death, your surviving spouse) must elect Company Health Care Continuation in order for your Eligible Dependents to elect to enroll in Company Health Care Continuation.

In limited circumstances, your spouse and/or dependent child may be eligible for COBRA continuation after Company Continuation ends. If your spouse or dependent child loses the Company Continuation because of a qualifying event, then the person who would lose health coverage under Company Continuation may elect COBRA coverage for a maximum period of 36 months from the date of the qualifying event that would cause the loss of Company Continuation. For example:

- If you divorce or are legally separated from your spouse while on Company Continuation, your spouse and dependent may elect COBRA continuation from the date they would lose Company Continuation coverage because of the divorce or legal separation.

- If a dependent child loses the Company Continuation because he or she no longer meets the definition of Eligible Dependent under the Plan (e.g., if he or she attains the maximum age to be a dependent), the child may elect COBRA continuation from the date the child loses coverage because he or she ceases to be an Eligible Dependent.

- If you lose Company Continuation coverage under the Plan because you become eligible for Medicare, then your spouse or dependent may elect COBRA continuation from the date they would lose coverage because of your Medicare-eligibility. (Your becoming eligible for Medicare will not result in a loss of Company Continuation for your spouse and dependents in every circumstance.)

You, the spouse (or former spouse) or dependent who would lose Company Continuation coverage must notify the Westinghouse Benefits Center within 60 days of the event that would cause the loss of coverage to be eligible to elect COBRA coverage following the event. If the Westinghouse Benefits Center is not notified of the event that would cause the loss of coverage within the 60-day period, the spouse (or former spouse) and/or dependents will not be eligible to elect COBRA continuation. You may notify the Westinghouse Benefits Center of this information through *ConnectBenefits On-Line* at www.mybenefitsdirectory.com/westinghouse. The spouse or dependent may notify the Westinghouse Benefits Center of this information by calling 1-800-890-3600, or by writing to the Westinghouse Benefits Center, 100 Half Day Road, P.O. Box 1478, Lincolnshire, IL 60069-1478.

Chapter 5 – Disability Coverage

Total Disability Management

All disability income benefits, including salary continuation, accident & sickness and long-term disability benefit coverages include a case management review program to assist employees' rehabilitation and timely recovery. The case management program will use registered nurse (R.N.) reviewers, as well as qualified physician advisors to conduct an online review of a disability and interact directly with the treating physician.

You must call the Total Disability Management Administrator within the first seven days following your first absence from work to be considered for any disability income benefits. The Total Disability Management Administrator can be reached by calling Benefits Connection at 1-800-890-3600 and selecting disability case management at the appropriate prompt. You initiate the case management process by calling the Total Disability Management Administrator to provide them with your physician's name and phone number, as well as other information necessary to review your disability claim. This requirement also applies if you become Totally Disabled while on Furlough or at work.

Appendix I contains “How To Report a Disability.” Please refer to this Appendix for more information about Total Disability management.

If the insurance carrier determines that you are not Totally Disabled, you must immediately return to employment with the Employer; if you do not return to employment with the Employer, or if you cannot return to employment because your position has been filled by another person or otherwise eliminated, then your employment with the Employer will be immediately terminated.

Salary Continuation

Salary Continuation is not provided under the Plan; instead it is provided to Full-Time and Part-Time Employees who are paid on a salaried basis pursuant to the Employer’s payroll policy. We list salary continuation here just to remind you that you must follow all the requirements for Salary Continuation – including the requirement that you call the Total Disability Management Administrator within seven days of your first absence from work – or you will not be eligible for Salary Continuation or Long-Term Disability Benefit Coverage.

Accident & Sickness (A&S) Benefit Coverage

The Benefit Provided By This Feature

The benefit provided by this feature of the Plan is the payment of premiums on a group Accident & Sickness disability insurance contract.

Your Coverage

Accident & Sickness Benefit Coverage provides you with payments that cover a portion of your Benefit Pay according to a schedule, if you are Totally Disabled, up to a maximum payment period of 26 weeks.

Please see the insurance booklet for Accident & Sickness Benefit Coverage, which contains the schedule of benefits, in Appendix H.

Special Eligibility Requirements

You must be a Full-Time Employee who is hourly-paid to be eligible to participate in Accident & Sickness Benefit Coverage. This eligibility requirement does not, however, affect any existing Accident & Sickness benefit for an active employee who was determined to be Totally Disabled before January 1, 2003.

Monthly Payment of Premiums

Each month, the Employer pays the premium required under the contract for each covered employee. There is no employee contribution required for this coverage.

Long-Term Disability (LTD) Benefit Coverage

The Benefit Provided By This Feature

The benefit provided by this feature of the Plan is the payment of premiums on a group long-term disability insurance contract.

Your Coverage

If you are unable to return to work due to your continued Total Disability after your salary continuation (for Full-Time Employees who are paid on a salaried basis) or Accident & Sickness Benefit Coverage (for Full-Time Employees who are paid on an hourly basis) is exhausted, Long-Term Disability Benefit Coverage, if elected, provides you with a benefit.

Special Eligibility Requirements

You must be a Full-Time Employee to be eligible to participate in Long-Term Disability Benefit Coverage.

Your Choices

You have three long-term disability benefit options:

- Replacement of 60% of your Benefit Pay, up to a maximum benefit of $10,000 a month;
- Replacement of 70% of your Benefit Pay, up to a maximum benefit of $11,667 a month; or
- No Coverage.

Coverage Provided

Please see the insurance booklet for Long-Term Disability Benefit Coverage in Appendix H for a complete explanation of how the insurance company determines your Benefit Pay and the conditions that you must satisfy to receive a benefit.

Long-term disability benefits are offset by, among other offsets, the Employer-paid portion of your Pension Plan benefit, state or federal workers' compensation disability or occupational disease benefits, Social Security benefits, or other disability benefits provided to comply with federal, state, or other laws. This means that your total monthly disability income from these sources cannot add up to more than the dollar maximum for the long-term disability option you select or your benefits from this coverage will be reduced. However, the benefit will be at least $150 per month.

If you do not enroll when first eligible, or if you would like to increase your coverage, evidence of insurability will be required. Coverage will become effective on the 1st of the month after the insurance carrier approves your coverage.

The Long-Term Disability Benefit Coverage does not provide benefits for disabilities that began during your first year of service with the Employer if you were treated for the condition before you were covered by the Long-Term Disability Benefit Coverage.

Participant Contributions

You must pay for the insurance coverage that you elect on an after-tax basis. Even though this feature of the Plan offers you a choice between three Coverage Levels, this choice is not one of the flexible benefit features. A chart showing your Long-Term Disability Benefit Coverage contribution amounts is included in Appendix J. For your convenience, the Employer will deduct any required contribution for disability coverage from your pay on an after-tax basis. If you have no pay, you will be billed for your contribution. If your contribution is not received for any reason within 30 days of the date due, disability coverage will be discontinued.

Chapter 6 – Life and Accidental Death and Dismemberment (AD&D) Insurance Coverage

Employer-Provided Basic Life and AD&D and Business Travel Accident

The Benefit Provided By This Feature

The benefit provided by this feature of the Plan is the payment of premiums on a group life and accidental death and dismemberment (AD&D) insurance contract.

Monthly Payment of Premiums

Each month, the Employer pays the premium required under the insurance contract for each covered employee.

Basic Life Insurance Coverage

Your Coverage

Eligible Full-Time Employees will automatically receive basic life insurance coverage equal to 1-1/2 times your Benefit Pay (with a minimum amount of $36,000 and a maximum amount of $50,000). This coverage pays the benefit to your named beneficiary(ies) if you die from any cause while you are covered.

Eligible Part-Time Employees automatically receive basic life insurance coverage equal to $3,750.

Basic Life Insurance Reduction for Active Employees Who Work Past Their 65th Birthday

Coverage reduces by 1.1 percent each month that you work beyond your Normal Retirement Date, to a minimum of 1/3 of the original amount of insurance at age 65. The reductions begin on the 1st of the month following your 65th birthday, with each additional reduction effective on the first day of each subsequent month of your employment.

Please see the insurance booklet for Basic Life Insurance Coverage in Appendix G.

Basic Accidental Death & Dismemberment (AD&D) Insurance Coverage

Your Coverage

This coverage applies if you have an accident and are killed or seriously injured. Eligible Full-Time and Part-Time Employees will automatically receive basic AD&D insurance coverage equal to your basic life insurance coverage amount. This coverage pays benefits in addition to other benefits you may receive.

Please see the insurance booklet for Basic AD&D Insurance Coverage in Appendix G.

Business Travel Accident Insurance Coverage

Your Coverage

This coverage pays business travel accident insurance benefits if you are killed or seriously hurt while traveling on the Employer's business. These benefits are in addition to any other benefits you may receive. Eligible Full-Time Employees automatically receive business travel accident insurance coverage equal to two times their Benefit Pay, with a minimum of $25,000 and a maximum of $750,000. Eligible Part-Time Employees automatically receive business travel accident insurance coverage equal to one times their Benefit Pay or $25,000, whichever is more.

Please see the insurance booklet for Business Travel Accident Insurance Coverage in Appendix M.

Optional Life and AD&D

A covered employee may choose to buy additional insurance coverage for himself and his family by paying the full premium for the optional insurance. (Even though this part of the Plan offers you a choice of buying optional insurance, some of these coverages are not part of the "cafeteria plan" under the Internal Revenue Code, because you must pay for some of the optional insurance on an after-tax basis.)

Group Universal Life (GUL) Program

The Benefit Provided By This Feature

(The group universal life program is not covered by ERISA, but we are listing it here for convenient reference.) The Group Universal Life (GUL) Program is an easy, affordable way to provide income protection for your family and save money for the future by combining life insurance with a cash accumulation account that earns tax-deferred interest.

Your Choices

You can choose to purchase Group Universal Life (GUL), up to four times your Benefit Pay, or $1,000,000 if less, through the Group Universal Life Program.

To enroll in this program or change your coverage amount, you need to contact the GUL insurance carrier directly by calling Benefits Connection and selecting Group Universal Life at the appropriate prompt. During your initial enrollment as a new hire or a newly eligible participant, you must submit a statement of health if you want to enroll for any amount more than the lesser of one times your Benefit Pay or more than $250,000. If you want to increase your coverage at any time in the future, you may also be required to submit a statement of health.

If you must submit a statement of health, the GUL insurance carrier will accept life insurance elections in accordance with its guidelines governing medical underwriting. The GUL insurance carrier solely determines the effective date of coverage once its medical review has been conducted. Depending upon your circumstances, approval by the GUL insurance carrier may take several months. During the period while the GUL insurance carrier is making its determination during your initial enrollment as a new hire or a newly eligible participant, you will be enrolled for GUL equal to the guaranteed issue amount. This amount is the lesser of one times your Benefit Pay or $250,000.

Grandfathered GUL Provisions

Individuals who were covered for amounts in excess of $1,000,000 as of December 31, 1999 were grandfathered with that coverage amount.

Individuals who were covered for amounts in excess of one times pay under Additional Life Insurance Coverage for Part-Time Employees as of December 31, 2003 were grandfathered with that coverage amount.

Monthly Payment of Premiums

Payments for this coverage are made on an after-tax basis. For your convenience, each month the Employer sends in premiums deducted from your pay on an after-tax basis and sends them to the GUL insurance carrier. If you have no pay, you will be billed for your contribution by the insurance carrier. If your contribution is not received for any reason within 30 days of the date due, GUL coverage will be discontinued.

Information on rates for this coverage is available in Appendix J.

Additional/Supplemental Life Insurance Coverage (Grandfathered as of 12/31/91)

The Benefit Provided by This Feature

The benefit provided by this feature of the Plan is the payment of premiums on a supplemental group life insurance contract for a closed group of employees.

Special Eligibility Requirements

You must have been enrolled in Additional/Supplemental Life Insurance Coverage on 12/31/91 and have been continuously enrolled in this coverage since 12/31/91 in order to be eligible for this coverage.

Your Choices

The initial coverage amounts were frozen as of 12/31/91. The only choice available is to continue or discontinue coverage. Any employee who discontinues this coverage during an annual enrollment period or at any other time for any reason, including transfer to an ineligible location or becoming re-employed as a regular Full-Time Employee again after retirement, is permanently opting out of this coverage and will not be given the opportunity to re-enroll at any time in the future.

Monthly Payment of Premiums

The employee paid portion of the cost of this coverage is made on a pre-tax basis. If you have no pay, you will be billed for your contribution. Each month, the Employer pays the required insurance premium for each covered employee. Information on rates for this coverage is in Appendix J.

Please see the insurance booklet for Additional/Supplemental Life Insurance coverage in Appendix G.

Dependent Life Insurance Coverage

The Benefit Provided By This Feature

The benefit provided by this feature of the Plan is the payment of premiums on a group life insurance contract.

Special Eligibility Requirements

You must be a Full-Time Employee to purchase this coverage for your Eligible Dependents.

Your Choices

This coverage lets you cover your spouse and children for life insurance benefits at favorable premium rates. You receive the dependent life insurance benefits in a lump sum if one of your Eligible Dependents dies from any cause while covered.

If you have dependents, you can choose dependent life insurance for your spouse and children. Dependent life insurance pays a benefit to you in the case of a covered dependent's death. You may choose from the following four options:

Option 1	Option 2	Option 3	Option 4
$5,000 spouse	$10,000 spouse	$15,000 spouse	$20,000 spouse
$1,000 each child	$2,000 each child	$3,000 each child	$4,000 each child

If you do not enroll when first eligible, or if you would like to increase your coverage (except if you elect to increase your coverage by one option level during the annual enrollment period), a statement of health for each of your covered dependents may be required. Coverage will become effective on the 1st of the month after the insurance carrier approves coverage for one or more of your dependents.

Monthly Payment of Premiums

Payments for this coverage are made on an after-tax basis. For your convenience, the Employer will deduct the amount owed, in accordance with the choices that you have made, from your pay on an after-tax basis, and the Employer will forward the premium required under the contract to the insurer. Information on rates for this coverage is in Appendix J. If your contribution is not received for any reason within 30 days of the date due, dependent life insurance coverage will be discontinued.

Please see the insurance booklet for Dependent Life Insurance Coverage in Appendix G.

Personal Accident Insurance Coverage for Yourself

The Benefit Provided By This Feature

The benefit provided by this feature of the Plan is the payment of premiums on a group life and accidental death and dismemberment (AD&D) insurance contract.

Special Eligibility Requirements

You must be a Full-Time Employee to purchase this coverage.

Your Choices

This coverage pays benefits for certain accidental injuries or death that could happen to you either on or off the job. These benefits are in addition to any other Plan benefits you may be eligible to receive.

You may purchase personal accident insurance coverage in $10,000 increments, up to a maximum of $350,000.

Monthly Payment of Premiums

Payments for this coverage are made on a pre-tax basis. If you have no pay, you will be billed for your contribution. Each month, the Employer pays the premium required under the contract for each covered employee, in accordance with the choices that you have made. Information on rates for this coverage is in Appendix J.

Please see the insurance booklet for Personal Accident Insurance Coverage in Appendix G.

Personal Accident Insurance Coverage for Your Dependents

The Benefit Provided By This Coverage

The benefit provided by this feature of the Plan is the payment of premiums on a group life and accidental death and dismemberment (AD&D) insurance contract.

Special Eligibility Requirements

You must be a Full-Time Employee to purchase this coverage for your Eligible Dependents.

Your Choices

This coverage pays benefits for certain accidental injuries or deaths that could happen to your dependents. These benefits are in addition to other Plan benefits you may be eligible to receive under the dependent life insurance coverage.

You may purchase personal accident insurance coverage for your family in increments of $10,000 for your spouse and $2,000 for each of your dependent children. You may choose a maximum of 10 increments, which would pay a maximum of $100,000 for your spouse and $20,000 for each of your dependent children.

Monthly Payment of Premiums

Payments for this coverage are made on an after-tax basis. For your convenience, the Employer will deduct the amount owed, in accordance with the choices that you have made, from your pay on an after-tax basis, and the Employer will forward the premium required under the contract to the insurer. Information on rates for this coverage is in Appendix J. If your contribution is not received for any reason within 30 days of the date due, personal accident insurance coverage will be discontinued.

Please see the insurance booklet for Personal Accident Insurance Coverage in Appendix G.

Beneficiary Designation

For Basic Life Insurance, Basic Accidental Death & Dismemberment, Business Travel Accident, Additional/Supplemental Life, and Personal Accident Insurance Coverage for Yourself

Your beneficiary is the person to whom the death benefits will be paid if you die while covered by the insurance. You are entitled to name a beneficiary for each of these coverages in which you are enrolled. You may name the same beneficiary for all coverages, or you may name a different beneficiary for each of the coverages. Who you can name as beneficiary, how you go about naming a beneficiary, and what happens if you don't name a beneficiary (or your beneficiary dies before you do) are all governed by the insurance contract. The beneficiary for Dependent Life Insurance Coverage and Personal Accident Insurance Coverage for your dependents is always yourself.

Beneficiary designations are made via the *Your Benefits Resources*™ Web site, which you can access through *ConnectBenefits On-Line* at www.mybenefitsdirectory.com/westinghouse. **After you designate your beneficiaries on the *Your Benefits Resources*™ Web site, you will receive a Beneficiary Designation Authorization Form, which you must sign, date and mail to the Westinghouse Benefits Center within 60 days of the date on the Form, or your beneficiary designation will not be valid.**

Please note: While the Westinghouse Benefits Center may assist you by providing a beneficiary designation form when you first enroll, always remember that the designation of your beneficiary is between you and the insurance carrier.

Please note also: If you name your spouse as beneficiary but then separate from your spouse or divorce your spouse, your beneficiary designation is not changed automatically. Likewise, if you name someone as beneficiary and that person dies, you do not have a beneficiary unless and until you name a new one. Be sure to complete and submit a new beneficiary designation form whenever circumstances change, so that your beneficiary designation will always be what you want.

For Group Universal Life (GUL)

Your beneficiary designation for GUL is a completely separate designation and is made on a completely different form and is sent directly to the GUL insurance carrier.

Chapter 7 – Other Benefits

Day Care Spending Account

The Benefit Provided By This Feature

The benefit provided by this feature is tax-free reimbursement for day care expenses. The best example is the cost of day care or nursery school or babysitting so that both you and your spouse can work. As you will see in a moment, unless your spouse is a full-time student or is incapacitated, a married employee cannot take advantage of this feature if the spouse doesn't work. This feature of the Plan is intended to be a separate written Plan for purposes of Section 129 of the Internal Revenue Code.

What's Good About Day Care Spending Accounts

Your day care expenses are normally paid with after-tax dollars. If you use this feature of the Plan, you can have those expenses paid with pre-tax dollars. You decide how much pay reduction (how much you would like to put into your Day Care Spending Account for the Plan Year) during your enrollment.

Participating in the Day Care Spending Account reduces your federal income taxes and FICA taxes. It also reduces your state and local income taxes in most states. (Unfortunately, reimbursement of day care expenses is still subject to state and local income tax in some jurisdictions, including Pennsylvania.)

How Day Care Spending Accounts Work

If you choose during your enrollment to contribute to the Day Care Spending Account for the Plan Year, the enrollment agreement constitutes a contract between you and the Employer, in which you choose an alternative package of pay and benefits:

- In the ordinary package of pay and benefits (that is, if you do not choose to contribute to the Day Care Spending Account), you get a certain amount of pay but no day care reimbursement.
- In the alternative package that you get by choosing to contribute to the Day Care Spending Account, you get a package in which the pay is less but, in addition, you get day care “reimbursement” under this feature. The amount of the reduction in the pay component is exactly equal to the day care reimbursement (the amount that you put into your Day Care Spending Account) that is available under this feature of the Plan.

It seems a little artificial, but this is how the law works: in the alternative package of pay and benefits, the amounts that used to be after-tax payments by the employee are now Employer payments. Since they are Employer payments, they are not subject to federal income tax or FICA.

What Kinds of Expenses Can Be Reimbursed

Under this feature of the Plan, you can be reimbursed for expenses you incur for the care of a dependent in your household, such as a spouse, child or parent that are necessary to enable you and your spouse, if married, to remain gainfully employed. They can include:

- care for a dependent under age 13 (this includes the expense of a day care center, provided that it complies with all applicable state and local regulations, it provides care for more than 6 individuals, and it receives fees, payments or grants for any of the individuals, regardless of whether the center is operated for profit),

- care for a spouse or dependent who is physically or mentally incapable of caring for himself (if the services are provided outside the home, the dependent must still spend at least 8 hours a day in the employee's household, which means this cannot be used for the expense of an aging parent who resides in a nursing home), and

- household services (such as a housekeeper or cook), provided that such services are related to providing day care for a dependent.

Before you decide to pay one of your children to watch the others, keep in mind that you cannot get reimbursement for these expenses if they are paid to a child of yours under age 19 or to anyone else that you or your spouse could claim as a dependent on your federal income tax return.

And day care assistance does not include the cost of an overnight camp or tuition for children in kindergarten or above.

For purposes of the Day Care Spending Account benefit, a person is not treated as a spouse if that individual (1) files a separate income tax return from you, (2) maintains a separate residence from you during the last six months of the taxable year, and (3) does not furnish more than one-half of the cost of maintaining your residence.

Day care expenses are described in section 21 of the Internal Revenue Code. The IRS publishes a helpful guide to reimbursable expenses called Publication 503 – Child and Dependent Care Expenses. You can get a free copy from the IRS by calling (800) TAX-FORM. You can also obtain Publication 503 on the Internet at www.irs.gov. You can also contact the Spending Account Administrator if you have any questions about whether an expense is reimbursable under the Day Care Spending Account.

How Much You Can Put Into Your Day Care Spending Account

You decide how much you would like to put into your Day Care Spending Account for the Plan Year, and that is the amount of day care expenses incurred during that year for which you are entitled to reimbursement. There are just two limitations:

- The total annual amount cannot be less than $120 per year or exceed $5,000 ($2,500 if you are married and file a separate federal income tax return). (Also, if you and your spouse both have Day Care Spending Accounts through your employers, you get one $5,000 limit between you, not two.)

- You cannot get reimbursement for more than your earned income or your spouse's earned income, whichever is less. (If your spouse has no earned income because he or she is a full-time student or is incapacitated, reimbursement is still permitted up to $200 per month if there are no children or $400 per month if there are children.)

In deciding how much you would like, however, you will want to keep in mind this rule, which is imposed by the Internal Revenue Service:

If you don't incur day care expenses during a particular Plan Year that use up the full amount that you put into your Day Care Spending Account for that Plan Year, the unused balance is lost forever.

This rule is sometimes known as “use it or lose it,” which is an accurate description. Therefore, you should use this arrangement for expenses that are predictable - reasonably certain to occur and reasonably predictable in amount. With day care assistance, this is usually quite easy to do.

During annual enrollment, if you don't change your Day Care Spending Account contribution amount, your current contribution amount will automatically be carried forward into the next Plan Year. If you want to change your current contribution amount for the next Plan Year, you must make your change during the

annual enrollment period through the *Your Benefits Resources*™ Web site, which you can access through *ConnectBenefits On-Line* at www.mybenefitsdirectory.com/westinghouse.

The Tax Credit Alternative

As an alternative to tax-free day care assistance, there is a tax credit in section 21 of the Internal Revenue Code for this same type of expenses, and you can take the tax credit without participating in this feature. Whether it's better to take the tax credit or use the Day Care Spending Account depends on your individual circumstances.

The maximum amount of Allowable Expenses that are taken into account in determining the tax credit increased in 2003 to $3,000 (for one qualifying dependent) and $6,000 (for two or more qualifying dependents). In addition, the tax credit now ranges between 20% and 35% of the expenses. The maximum amount that can be reimbursed through the Day Care Spending Account remains fixed at $5,000 per year (or $2,500 in the case of a separate return).

For most taxpayers, using the Day Care Spending Account produces greater tax benefits than the dependent care tax credit because the Day Care Spending Account reduces your earned income, which results in an increase in your earned income credit. There are, however, exceptions to this rule; for example, claiming the tax credit may produce greater tax benefits where the taxpayer's W-2 income before Day Care Spending Account salary reductions is roughly $12,000 to $15,000. Your Employer cannot offer you any personal advice on tax issues. Please contact your tax advisor, or refer to IRS publication 503, to determine whether the Day Care Spending Account or the dependent care tax credit option is better for you.

When To Submit Expenses For Reimbursement

Unlike Health Care Spending Accounts, where you can be reimbursed at any time during the year for the full annual amount that you have committed to your Health Care Spending Account, under this feature of the Plan you can be reimbursed only up to the total amount of pay reduction that has accrued up to that point in the Plan Year. But you should submit the bill anyway. The Spending Account Administrator will pay as much as possible and hold the rest until additional pay reductions have accumulated to pay the rest.

Submit all expenses as soon as possible - in no event later than 90 days after the end of the Plan Year. Pay reduction during a particular Plan Year may be used to reimburse only expenses incurred during that Plan Year - not from earlier years or later years. And, as you know, any unused balance at the end of the year is lost forever. To avoid losing it, you must use it up with expenses incurred in that same Plan Year. That means expenses incurred in the following year cannot be paid out of the balance remaining at the end of the previous year.

Expenses are incurred when the day care is provided. This is true even if the provider does not bill you (or you don't pay) until later.

EXAMPLE: The day care center provides day care for your child in the month of December but doesn't send you a bill until January. The expense was incurred in the first year (not the second year) and can only be reimbursed from the amount of benefit dollars (or pay reduction) that you committed to the Day Care Spending Account for the first year.

How to Submit Claims For Reimbursement

If you are entitled to reimbursement of a day care expense under this Plan, all you have to do is file a claim form with the Spending Account Administrator and substantiate the claim. If you need a copy of the claim form, you can obtain one through the *Your Benefits Resources*™ Web site, the Spending Account Administrator's Web site, or by calling the Spending Account Administrator. You can reach the *Your Benefits Resources*™ and the Spending Account Administrator's Web sites through *ConnectBenefits On-Line* at www.mybenefitsdirectory.com/westinghouse; you can also reach the Spending Account Administrator through Benefits Connection at 1-800-890-3600.

To substantiate the claim, you have to present a bill from the day care provider showing when the care was rendered, the dependent for whom the care was rendered, the amount charged, and the name, address and taxpayer identification number (or Social Security Number) of the provider.

The Spending Account Administrator will review your claim within 90 days of the receipt of your claim. If the claim is granted, the Spending Account Administrator will simply send you a check or, if you have submitted the proper form, will direct deposit your reimbursement into your designated account. If for some reason the claim is not granted, the Spending Account Administrator will notify you in writing after you filed the claim and point out the specific reasons and Plan provisions on which the denial is based, describe any additional information needed to complete the claim, and describe the appeal procedure.

No later than January 31 of each year, the Spending Account Administrator will give you a statement showing the amount of reimbursement for day care assistance that you received under this feature of the Plan during the previous year.

When Your Employment Terminates

When your employment terminates, you are no longer eligible to make contributions to the Day Care Spending Account. You can continue to get reimbursement (up to the accumulated balance of your pay reductions) for expenses incurred prior to the termination of your employment, but not for expenses incurred after that date.

Funding

This feature of the Plan – reimbursement for day care expenses – is not funded or insured in any way. In return for your commitment of pay reduction to day care reimbursement, what you get is the Employer's contractual obligation to reimburse you for day care expenses under the terms of this Plan. These reimbursements are paid from the Employer's general assets; they are not covered by any insurance contract and are not paid from any trust.

Long-Term Care Insurance Coverage

The Benefit Provided By This Feature

The benefit provided by this feature of the Plan is the payment of premiums on an insured long-term care coverage contract.

Special Eligibility Requirements

You must be a Full-Time Employee to purchase this coverage.

Your Choices

You may choose to purchase long-term care insurance for yourself and for certain eligible relatives described below. Generally speaking, long-term care insurance coverage offers benefits that go beyond medical care and nursing care to provide the assistance a person would need if the person has a chronic

illness or disability that leaves the person unable to care for himself or herself for an extended period of time.

The long-term care insurance coverage offers three options for long-term care insurance. These options, which differ by the maximum daily benefit and corresponding lifetime maximum benefit, are described in detail in the literature prepared by the insurance carrier, which is attached as Appendix O. You may purchase long-term care coverage for any or all of the following individuals: you; your spouse; your parent(s); your in-law(s); your grandparent(s); and/or your spouse's grandparent(s). We refer to each of these people as an "eligible relative." The amount of the premium that you will pay depends on the age of the person covered by the long-term care insurance.

Unless you are continuing the long-term care insurance coverage that you obtained for yourself or an eligible relative through the prior long-term care insurance carrier, or you enroll yourself during the initial enrollment period which is 31 days from the date your Enrollment Notice is generated, you will be required to submit a statement of good health with respect to the person for whom the long-term care insurance coverage is sought before that person will be enrolled in the coverage option selected.

The long-term care insurance carrier will accept long-term care insurance elections in accordance with its guidelines governing medical underwriting. The long-term care insurance carrier solely determines the effective date of coverage once its medical review has been conducted. Depending upon circumstances, the long-term care insurance carrier may take several months to determine whether a person is eligible for long-term care insurance coverage.

Grandfathered Long-Term Care Provisions

If you were enrolled in long-term care through the prior long-term care insurance carrier, your rates will be based on your age at the time you enrolled with the prior carrier.

Monthly Payment of Premiums

Rates for long-term care insurance are age-related. Premiums for your own and your spouse's coverage can be payroll-deducted on an after-tax basis. Premiums for your and your spouse's coverage if you are not receiving a paycheck, and premiums for your parents, parents-in-law, grandparents and/or grandparents-in-law will be billed directly by the insurance carrier. Any long-term care insurance will terminate if you fail to pay the premium due for the long-term care insurance within the time specified in the insurer's literature.

Please see the group insurance contract and group application for Long-Term Care Insurance Coverage in Appendix O for more information.

Chapter 8 – How Changes In Your Employment Situation Affect Your Participation in Your Benefit Coverages

This section contains summaries of extensions, if any, of the benefits that may be continued during certain events.

Continuation of coverage, whether Company Continuation or COBRA, can only occur if the employee is enrolled in coverage on the day before the event. If the employee is not enrolled in coverage on the day before an event, the employee cannot continue coverage, as there is no coverage to continue.

When one of the events listed below occurs, your coverage(s) either stop at midnight on your last day worked, continue under Company Continuation if you pay any required contributions, or continue under COBRA if you elect it and pay any required contributions. The charts below give you more information about what happens to each benefit coverage when certain events occur.

If You Are On an Approved Unpaid Leave of Absence

This section contains summaries of the extension, if any, of the benefits that may be continued during your Leave of Absence (please see the definition of Leave of Absence in Appendix B). During your Leave of Absence, if another employer's plan covers you and your dependents, your benefits under the Plan will be reduced by the other employer's benefits.

Family and Medical Leave (FMLA)*

Medical and Dental Coverage	Coverage automatically continues, if you are enrolled, for yourself and your Eligible Dependents during the length of your FMLA as long as you pay the active employee contributions in advance. If you are a regular Full-Time Employee who opted out of medical coverage, and therefore received opt-out credits while an active employee, you will not receive these opt-out credits while you are on your FMLA.
Employee Assistance Program	Coverage automatically continues for yourself and your Eligible Dependents during the length of your FMLA.
Accident & Sickness Benefit Coverage	Income benefit continues, if applicable.
Long-Term Disability Benefit Coverage	Coverage automatically continues, if you are enrolled, for the length of your FMLA as long as you pay the active employee contributions in advance.
Basic Life Insurance Coverage and Basic AD&D Insurance Coverage	Coverage continues during the length of your FMLA.
Business Travel Accident Insurance Coverage	Coverage ends at midnight on your last day worked.
Additional/Supplemental Life Insurance Coverage	If enrolled, coverage continues during the length of your FMLA by paying the required contribution in advance. If you do not continue your additional/supplemental life insurance coverage during your FMLA, you will not be given the opportunity to re-enroll for this coverage upon your return or at any time in the future.

Group Universal Life	If enrolled, you may continue GUL directly through the GUL insurance carrier during your FMLA according to the provisions of that coverage. The GUL insurance carrier will bill you for the cost of your coverage.
Dependent Life Insurance Coverage	If enrolled, coverage continues during the length of your FMLA by paying the required contribution in advance.
Personal Accident Insurance Coverage for Yourself and Your Dependents	If enrolled, coverage continues during the length of your FMLA by paying the required contribution in advance.
Long-Term Care Insurance Coverage	If enrolled, you may continue Long-Term Care Insurance Coverage (LTC) directly through the LTC insurance carrier according to the provisions of that coverage. The LTC insurance carrier will bill you for the cost of your coverage.
Health Care Spending Account	If you participated in the Health Care Spending Account immediately prior to your FMLA, you may continue to contribute to your Account for the duration of your FMLA, until the end of the calendar year, by paying the required contribution on an after-tax basis. The Billing Administrator will bill you for your contributions. You may also choose to not make Health Care Spending Account contributions after you begin your FMLA. If you choose not to make further contributions, you will only be able to submit claims for reimbursement of expenses that were incurred before your FMLA began and during the same calendar year as your FMLA began. Contact the Westinghouse Benefits Center to discontinue these contributions. If you return to work before the end of the calendar year in which your FMLA began, your Health Care Spending Account contributions will be automatically reinstated upon your return.
Day Care Spending Account	No additional contributions to the Day Care Spending Account are permitted after you begin your FMLA. You may continue to have access to your Account for eligible expenses (*i.e.*, expenses that you incurred to enable you and your spouse (if married) to work) incurred during the calendar year in which you begin your FMLA, up to the balance remaining in your Account. If you return to work before the end of the calendar year in which your FMLA began, your Day Care Spending Account contributions will be automatically reinstated upon your return.

*If you are on a leave to which you are entitled under the federal Family and Medical Leave Act of 1993, you will not be considered to have ceased active employment under any coverage of the Plan that constitutes a "group health plan" as long as you are on a leave to which you are entitled by the FMLA.

Personal/Educational Leave of Absence

Medical and Dental Coverage	Coverage ends at midnight on your last day worked. You may continue these coverages for yourself and your Eligible Dependents through COBRA, paying active rates for the first (12) months and full COBRA rates thereafter until the COBRA continuation period expires. If you are a regular Full-Time Employee who opted out of medical coverage, and therefore received opt-out credits while an active employee, you will not receive these opt-out credits while you are on your Leave of Absence.
Employee Assistance Program	Coverage ends at midnight on your last day worked. You may continue this coverage for yourself and your Eligible Dependents through COBRA.

Accident & Sickness Benefit Coverage and Long-Term Disability Benefit Coverage	Coverage ends at midnight on your last day worked.
Basic Life Insurance Coverage	Coverage continues during your Leave of Absence for up to 1 year. Conversion available after coverage ends.
Basic AD&D Insurance Coverage	Coverage continues during your Leave of Absence for up to 1 year.
Business Travel Accident Insurance Coverage	Coverage ends at midnight on your last day worked.
Additional/Supplemental Life Insurance Coverage	If enrolled, coverage continues during your Leave of Absence for up to 1 year by paying the required contribution in advance. If you do not continue your additional/supplemental life insurance coverage during your Leave of Absence, you will not be given the opportunity to re-enroll for this coverage upon your return or at any time in the future. Conversion available after coverage ends.
Group Universal Life	If enrolled, you may continue GUL directly through the GUL insurance carrier during your Leave of Absence according to the provisions of that coverage. The GUL insurance carrier will bill you for the cost of your coverage.
Dependent Life Insurance Coverage	If enrolled, coverage continues during your Leave of Absence for up to 1 year by paying the required contribution in advance. Conversion available after coverage ends.
Personal Accident Insurance Coverage for Yourself and Your Dependents	Coverage ends at midnight on your last day worked.
Long-Term Care Insurance Coverage	If enrolled, you may continue Long-Term Care Insurance Coverage (LTC) directly through the LTC insurance carrier according to the provisions of that coverage. The LTC insurance carrier will bill you for the cost of your coverage.
Health Care Spending Account	If you participated in the Health Care Spending Account immediately prior to your Leave, you may continue to contribute to your Account for the balance of the calendar year if you elect COBRA and pay the required COBRA premium. If you choose not to make further contributions through COBRA, you will only be able to submit claims for reimbursement of expenses that were incurred before your Leave began and during the same calendar year as your Leave began. If you return to work before the end of the calendar year in which your Leave began, your Health Care Spending Account contributions will be automatically reinstated upon your return.
Day Care Spending Account	No additional contributions to the Day Care Spending Account are permitted after you begin your Leave of Absence. You may continue to have access to your Account for eligible expenses (*i.e.*, expenses that you incurred to enable you and your spouse (if married) to work) that you incurred during the calendar year in which you begin your Leave of Absence, up to the balance remaining in your Account. If you return to work before the end of the calendar year in which your Leave of Absence began, your Day Care Spending Account contributions will be automatically reinstated upon your return.

Note: For any coverage that you are eligible to continue under COBRA, coverage will stop at midnight on your last day worked unless you timely elect and pay for COBRA coverage after you receive your COBRA notification from the COBRA Administrator. If you timely elect and pay for COBRA coverage, your coverage will be reinstated back to the termination date.

For Part-Time Employees, benefits during a Personal/Educational Leave of Absence are as described in the chart above except that:

- **Medical and dental coverage and the Employee Assistance Program:** Coverage ends at midnight on your last day worked. You may continue these coverages for yourself and your Eligible Dependents through COBRA, paying full COBRA rates until the COBRA continuation period expires.
- **Basic Life Insurance Coverage:** Coverage ends at midnight on your last day worked. You may apply for an individual converted life insurance policy if you apply to the insurance carrier and pay for the coverage within 31 days after coverage stops.
- **Basic Accidental Death & Dismemberment Insurance Coverage:** Coverage ends at midnight on your last day worked.

Any Other Type of Leave of Absence**

Medical and Dental Coverage	Coverage ends at midnight on your last day worked. You may continue these coverages for yourself and your Eligible Dependents through COBRA, paying active rates for the length of your Leave. If you are a regular Full-Time Employee who opted out of medical coverage, and therefore received opt-out credits while an active employee, you will not receive these opt-out credits while you are on your Leave of Absence.
Employee Assistance Program	Coverage ends at midnight on your last day worked. You may continue this coverage for yourself and your Eligible Dependents through COBRA at no cost for the length of your Leave.
Accident & Sickness Benefit Coverage and Long-Term Disability Benefit Coverage	Coverage ends at midnight on your last day worked.
Basic Life Insurance Coverage and Basic AD&D Insurance Coverage	Coverage continues during your Leave of Absence.
Business Travel Accident Insurance Coverage	Coverage ends at midnight on your last day worked.
Additional/Supplemental Life Insurance Coverage	If enrolled, coverage continues during your Leave of Absence by paying the required contribution in advance. If you do not continue your additional/supplemental life insurance coverage during your Leave of Absence, you will not be given the opportunity to re-enroll for this coverage upon your return or at any time in the future.
Group Universal Life	If enrolled, you may continue GUL directly through the GUL insurance carrier during your Leave of Absence according to the provisions of that coverage. The GUL insurance carrier will bill you for the cost of your coverage.
Dependent Life Insurance Coverage	If enrolled, coverage continues during your Leave of Absence by paying the required contribution in advance.
Personal Accident Insurance Coverage for Yourself and your Dependents	If enrolled, coverage continues during your Leave of Absence by paying the required contribution in advance.
Long-Term Care Insurance Coverage	If enrolled, you may continue Long-Term Care Insurance Coverage (LTC) directly through the LTC insurance carrier according to the provisions of that coverage. The LTC insurance carrier will bill you for the cost of your coverage.

Health Care Spending Account	If you participated in the Health Care Spending Account immediately prior to your Leave, you may continue to contribute to your Account for the balance of the calendar year through COBRA if you elect COBRA and pay the required COBRA premium. If you choose not to make further contributions through COBRA, you will only be able to submit claims for reimbursement of expenses that were incurred before your Leave began and during the same calendar year as your Leave began. If you return to work before the end of the calendar year in which your Leave began, your Health Care Spending Account contributions will be automatically reinstated upon your return.
Day Care Spending Account	No additional contributions to the Day Care Spending Account are permitted after you begin your Leave of Absence. You may continue to have access to your Account for eligible expenses (*i.e.* expenses that you incurred to enable you and your spouse (if married) to work) incurred during the calendar year in which you begin your Leave of Absence, up to the balance remaining in your Account. If you return to work before the end of the calendar year in which your Leave of Absence began, your Day Care Spending Account contributions will be automatically reinstated upon your return.

** If you are absent due to military service, you will be considered on Leave of Absence and treated the same as any other employee on Leave of Absence with regard to any coverage of the Plan where benefits do not depend on length of service unless and until you knowingly give written notice of intent not to return in accordance with the federal Uniformed Service Employment and Reemployment Rights Act of 1994.

Note: For any coverage that you are eligible to continue under COBRA, coverage will stop at midnight on your last day worked unless you timely elect and pay for COBRA coverage after you receive your COBRA notification from the COBRA Administrator. If you timely elect and pay for COBRA coverage, your coverage will be reinstated back to the termination date.

For Part-Time Employees, benefits during any other type of Leave of Absence are as described in the chart above except that:

- **Medical and dental coverage and the Employee Assistance Program:** Coverage ends at midnight on your last day worked. You may continue these coverages for yourself and your Eligible Dependents through COBRA, paying full COBRA rates until the COBRA continuation period expires.
- **Basic Life Insurance Coverage:** Coverage ends at midnight on your last day worked. You may apply for an individual converted life insurance policy if you apply to the insurance carrier and pay for the coverage within 31 days after coverage stops.
- **Basic Accidental Death & Dismemberment Insurance Coverage:** Coverage ends at midnight on your last day worked.

When You Return From Your Leave of Absence

If you return to work in the same calendar year as when your Leave of Absence began, you will be reinstated in the same health and welfare benefit elections that you had as an active employee. This includes all the health and welfare benefits that you had as an active employee, even those that you may not have continued while on your Leave of Absence. The only exceptions to this are as follows: If you are a Full-Time Employee who chose not to continue Additional/Supplemental Life Insurance during your Leave of Absence, you are not permitted to re-enroll in this coverage when you return from your Leave of Absence or at any time in the future. Also, if you did not continue certain life and disability coverages while on your Leave of Absence, a statement of health may be required to re-enroll in those coverages upon your return to work.

If you return to work in a different calendar year from when your Leave of Absence began, you will receive an Enrollment Notice when you return to work. You have 31 days from the date of your Enrollment Notice to re-enroll for benefits via the *Your Benefits Resources* Web site. If you do not re-enroll for benefits during this 31-day period, the benefits that you last had as an active employee will be reinstated.

If You Become Disabled

This section contains summaries of the extension, if any, of the benefits that may be continued if you cannot work due to a Total Disability.

You must call the Total Disability Management Administrator as described in Chapter 5 and in Appendices H and I within 7 days of your first workday missed in order to be eligible for the maximum benefits during your Total Disability.

If you do not return to work within 24 months from your last day worked, your employment with the Employer will be terminated. Your benefits coverage may continue after the termination of your employment as described in this section. If you are eligible to Retire before your employment is terminated (i.e., 24 months from your last day worked), you must inform your local human resources office that you want to **Retire before your employment is terminated**. After your employment is terminated, you cannot go back and Retire as an active employee; thus, for example, if you do not Retire as an active employee, you will not be eligible for retiree medical and dental coverage.

Medical Coverage	Through Company Continuation, if you are enrolled, coverage automatically continues for yourself and your Eligible Dependents during your Total Disability for 6 months or the length of the salary continuation period if longer, then COBRA. No contributions are required for the period of salary continuation paid at 50%, during the period of Accident & Sickness Benefit Coverage payments, and for the first 18 months on COBRA. COBRA continues for another 12 months (to 36 months from last day worked) by paying active rates. If you are Totally Disabled because of an Employer work-related sickness or injury, workers' compensation will be the primary payer for medical expenses relating to that sickness or injury and the Plan's medical coverage will be considered the secondary payer for medical expenses relating to that sickness or injury. If it is determined by the insurance carrier that you are Totally and Permanently Disabled, and you have at least ten years of Eligibility Service, please see the section entitled "If You Become Totally and Permanently Disabled" on page 62 of this document. If you are a regular Full-Time Employee who opted out of medical coverage, and therefore received opt-out credits while an active employee, you will not receive these opt-out credits while you are disabled.
Dental Coverage	Through Company Continuation, if you are enrolled, coverage automatically continues for yourself and your Eligible Dependents during your Total Disability for 6 months or the length of the salary continuation period if longer, then COBRA. No contributions are required for the period of salary continuation paid at 50%, during the period of Accident & Sickness Benefit Coverage payments, and for the first 18 months on COBRA. COBRA continues for another 12 months (to 36 months from last day worked) by paying active rates.
Employee Assistance Program	Through Company Continuation, coverage automatically continues for yourself and your Eligible Dependents during your Total Disability for 6 months or the length of the salary continuation period if longer, then COBRA, paying full COBRA rates until the COBRA continuation period expires.
Accident & Sickness Benefit Coverage	If you are approved for benefits under this coverage, you will continue to receive whatever accident and sickness benefits you are eligible to receive as long as you remain Totally Disabled, as determined by the insurance carrier, but not beyond the maximum benefit period (26 weeks).

Long-Term Disability Benefit Coverage	If you are enrolled in Long-Term Disability Benefit Coverage and you are approved for benefits, you will receive long-term disability benefits as long as you remain Totally Disabled, as determined by the insurance carrier. The Employer pays for the cost of coverage after your pay or wages stop. The Long-Term Disability Benefit Coverage provides that benefits are not payable for disabilities that began during your first year of service with the Employer, if you were treated for the condition before you were covered by the long-term disability coverage. The insurance carrier for the disability programs will determine if benefits are payable in accordance with the provisions of the insurance contract.
Basic Life Insurance Coverage	<u>If you have less than one year of Eligibility Service or are age 65 or older when your disability begins:</u> Coverage continues as long as you are Totally Disabled, but not more than 1 year from your last day worked. You may then apply for an individual converted life insurance policy if you apply to the insurance carrier and pay for the coverage within 31 days after coverage stops. <u>If you have at least one year but less than 10 years of Eligibility Service and are under 65 years old when your disability begins:</u> Coverage continues as long as you are Totally Disabled up to the 1st of the month after your 65th birthday. You may then apply for an individual converted life insurance policy if you apply to the insurance carrier and pay for the coverage within 31 days after coverage stops. <u>If you have at least 10 years of Eligibility Service and are under 65 years old when your disability begins:</u> Coverage continues as long as you are Totally Disabled including past your 65th birthday but reduces by 5% each month after age 65, beginning on the 1st of the month following your 65th birthday, until your basic life insurance benefit is 1/3 of the amount you had immediately prior to your 65th birthday or $2,500, whichever is more. To continue receiving these benefits, you must give proof of your Total Disability to the insurance carrier when asked.
Basic AD&D Insurance Coverage	Coverage continues for 12 months as long as you remain Totally Disabled.
Business Travel Accident Insurance Coverage	Coverage ends at midnight on your last day worked.

Additional/Supplemental Life Insurance Coverage	<u>If you have less than 10 years of Eligibility Service:</u> If enrolled, coverage continues in full until you reach age 65 as long as you remain Totally Disabled. The Employer pays for the cost of coverage after your pay or wages stop. When coverage ends, you may apply for an individual converted life insurance policy if you apply to the insurance carrier and pay for the coverage within 31 days after coverage stops. <u>If you have at least ten years of Eligibility Service:</u> If enrolled, coverage continues in full until you reach age 65 as long as you remain Totally Disabled. The Employer pays for the cost of coverage after your pay or wages stop. When you reach age 65, your coverage reduces by 5% each month until your benefit is 1/3 of the original amount in effect on December 31, 1991. If your Total Disability ends and you do not return to work for the Employer, you may apply for an individual converted life insurance policy if you apply to the insurance carrier and pay for the coverage within 31 days after coverage stops.
Group Universal Life	If enrolled, you may continue GUL directly through the GUL insurance carrier according to the provisions of that coverage. The GUL insurance carrier will bill you for the cost of your coverage.
Dependent Life Insurance Coverage	If enrolled, coverage continues for 12 months as long as you remain Totally Disabled. The Employer pays for the cost of coverage after your pay or wages stop. After coverage stops, you may apply for an individual converted life insurance policy if you apply to the insurance carrier and pay for the coverage within 31 days after coverage ends.
Personal Accident Insurance Coverage for Yourself and Your Dependents	If enrolled, coverage continues for 12 months as long as you remain Totally Disabled. No contributions are required after your pay or wages stop.
Long-Term Care Insurance Coverage	If enrolled, you may continue Long-Term Care Insurance Coverage (LTC) directly through the LTC insurance carrier according to the provisions of that coverage. The LTC insurance carrier will bill you for the cost of your coverage.
Health Care Spending Account	Company Continuation for 6 months, or length of salary continuation period if longer by paying active contribution rate (payroll deduction for period of salary continuance; direct billed for contributions during period of Accident and Sickness); then COBRA, paying full COBRA rate until the end of the calendar year. If you choose not to make further contributions through COBRA, you will only be able to submit claims for reimbursement of expenses that were incurred through the end of the Company Continuation period or, if longer, the salary continuation period, and in the same calendar year as the longer of the Company Continuation period or the salary continuance period. If you return to work before the end of the calendar year in which your disability began, your Health Care Spending Account contributions will be automatically reinstated upon your return.

Day Care Spending Account	No additional contributions to the Day Care Spending Account are permitted after your disability begins. You may continue to have access to your Account for eligible expenses (*i.e.*, expenses that you incurred to enable you and your spouse (if married) to work) incurred during the calendar year in which your disability began, up to the balance remaining in your Account. If you return to work before the end of the calendar year in which your disability began, your Day Care Spending Account contributions will be automatically reinstated upon your return.

Note: Total Disability provisions continue as long as you remain Totally Disabled as certified by the Total Disability Management Administrator. (Exception: If you are Laid-Off or Permanently Separated while on disability, Layoff or Permanent Separation provisions described on pages 67-70 apply on the date of Layoff or Permanent Separation.)

All benefit deductions continue during the period of 100% salary continuation; the Employer pays Long-Term Disability premiums and imputes income during periods of 50% salary continuation, Accident and Sickness, and Long-Term Disability. You are automatically enrolled in COBRA coverage after 6 months or, if longer, after the salary continuation period. If you do not want COBRA coverage for all or part of your health care coverage continuation under COBRA (medical, dental, the Employee Assistance Program and the Health Care Spending Account), you need to notify the COBRA Administrator.

For Part-Time Employees, benefits during a Total Disability are as described in the chart above except that:

- **Medical and dental coverage:** Company Continuation for 6 months, or length of salary continuation period if longer; then COBRA, paying full COBRA rate until COBRA continuation period expires. No contributions for period of salary continuation paid at 50%.
- **Basic Life Insurance Coverage:** Company Continuation for 6 months, or length of salary continuation period if longer. Conversion available when coverage ends.
- **Basic Accidental Death & Dismemberment Insurance Coverage:** Coverage ends at midnight on your last day worked.

When You Return From Your Total Disability

If you return to work in the same calendar year as when your Total Disability began, you will be reinstated in the same health and welfare benefit elections as you had as an active employee. This includes all the health and welfare benefits that you had as an active employee, even those that you may not have continued while you were Totally Disabled. The only exceptions to this are as follows: If you are a Full-Time Employee who chose not to continue Additional/Supplemental Life Insurance during your Total Disability, you are not permitted to re-enroll in this coverage when you return from disability or at any time in the future. If you did not continue certain life and disability coverages while you were Totally Disabled, a statement of health may be required to re-enroll in those coverages upon your return to work.

If you return to work in a different calendar year from when your disability began, you will receive an Enrollment Notice when you return to work. You have 31 days from the date of your Enrollment Notice to re-enroll for benefits via the *Your Benefits Resources* Web site. If you do not re-enroll for benefits during this 31-day period, the benefits that you last had as an active employee will be reinstated.

If You Become Totally and Permanently Disabled

If you are certified as Totally and Permanently Disabled by the insurance carrier, the only provision that is different from those described in the section “If You Become Disabled” on page 59 of this document relates to medical coverage. The special provisions relating to medical coverage for those who are Totally and Permanently Disabled are described below.

Medical Coverage

When your medical coverage ends, as described in the section "If You Become Disabled" on page 59 of this document, you and your spouse may be eligible for Special Programs with Medicare (SPM). To be eligible for SPM, you must:

- Have at least 10 years of Eligibility Service;
- Be under age 65 at the time your disability occurs; and
- The Total Disability insurance carrier must determine that your disability is Total and Permanent.

Please see the definition of Total and Permanent Disability in Appendix B. SPM is available whether or not you or your spouse are eligible for Medicare and is effective after the disability medical coverage provisions, described previously on page 59, ends.

Special Programs with Medicare (SPM)

If you are eligible, you and your spouse are automatically enrolled in SPM. If you do not want SPM coverage, call the Westinghouse Benefits Center to discontinue coverage; however, if you stop SPM for any reason at any time, you cannot re-enroll in that coverage at any time in the future.

The "special programs" under SPM are the prescription drug program and the hospital program.

- Prescription Drug Program
  - — This program provides benefits for prescription drugs and medicines. Benefits will be paid for covered prescription drugs that are Medically Necessary and Appropriate for treatment of a sickness or injury that is not Job-Related. Covered prescription drugs must be prescribed in writing by a doctor and dispensed by a licensed pharmacist.
  - — Prescription drug coverage is provided through a Network Administrator, and the Network Administrator's pharmacies must be used in order to receive the highest benefit. You will be reimbursed according to the SPM benefit schedule in Appendix C.

  No Deductible is required for covered prescription drugs.

  Covered and Non-Covered Prescription Drugs and Services:

  - — Prescription drug coverage does not pay for the services that are listed in Appendix E. The list of non-covered services, which is determined by the Network Administrator, is subject to change without advance notice. If you are uncertain whether a prescription drug is covered, please contact the Network Administrator.
  - — For prescription drug coverage details, please refer to Appendix C.

  Out-of-Network Retail Benefits:

  - — If you choose to go to an out-of-network retail pharmacy, you must pay the full cost of the prescription at the time of purchase. Then you must submit a claim form with the required information to the Network Administrator. You will be reimbursed according to the benefit schedule in Appendix C.

- Hospital Program

  — This program pays benefits for hospital confinements for sickness or injury that is not Job-Related. The benefit is $600 for the first day of hospital confinement that occurs within a Benefit Period (see Appendix B for the definition of Benefit Period), up to a combined Lifetime Maximum of $60,000 for you and your spouse.

  — If you stay in a government tuberculosis hospital or government psychiatric hospital, the hospital program pays $10 per day after your Medicare benefits run out.

  — If you or your spouse cannot receive Medicare benefits because you live or travel outside the United States, the hospital program provides coverage for expenses normally covered by medical coverage for hospital, surgical and X-ray and lab exam expenses. Each calendar year, you must first pay $25 of any covered medical bills you have. After that, the hospital program pays up to $225 of covered charges in full, plus 85% of covered charges over $225. These benefits count toward the $60,000 combined hospital program limit described above.

  — If you die before reaching this $60,000 combined maximum, your spouse can continue to receive these benefits until the $60,000 combined Lifetime Maximum is reached.

If You Voluntarily Quit or Your Employment is Involuntarily Terminated (not Layoff or Permanent Separation)

Medical and Dental Coverage and the Employee Assistance Program	Coverage ends at midnight on your last day worked. You may continue coverage for yourself and your Eligible Dependents through COBRA, paying full COBRA rates until the COBRA continuation period expires.
Accident & Sickness Benefit Coverage, Long-Term Disability Benefit Coverage, Basic AD&D Insurance Coverage, Business Travel Accident Insurance Coverage, Personal Accident Insurance Coverage for Yourself and Your Dependents	Coverage stops at midnight on the last day worked.
Basic Life Insurance Coverage, Additional/Supplemental Life Insurance Coverage, Dependent Life Insurance Coverage	Coverage ends at midnight on your last day worked. You may apply for an individual converted life insurance policy if you apply to the insurance carrier and pay for the coverage within 31 days after coverage stops.
Group Universal Life	If enrolled, you may continue GUL directly through the GUL insurance carrier according to the provisions of that coverage. The GUL insurance carrier will bill you for the cost of your coverage.
Long-Term Care Insurance Coverage	If enrolled, you may continue Long-Term Care Insurance Coverage (LTC) directly through the LTC insurance carrier according to the provisions of that coverage. The LTC insurance carrier will bill you for the cost of your coverage.
Health Care Spending Account	If you participated in the Health Care Spending Account immediately prior to your last day worked, you may continue to contribute to your Account for the balance of the calendar year through COBRA. If you choose not to make further contributions through COBRA, you will only be able to submit claims for reimbursement of expenses that were incurred in the calendar year in which your last day worked occurred, and which were incurred before your last day worked.
Day Care Spending Account	No additional contributions to the Day Care Spending Account are permitted after your last day worked. You may continue to have access to your Account for eligible expenses (*i.e.*, expenses that you incurred to enable you and your spouse (if married) to work) incurred during the calendar year in which your last day worked occurred, up to the balance remaining in your Account.

If You Are Furloughed

Benefit coverages continue during a Furlough period according to the following provisions:

Medical and Dental Coverage	If enrolled, coverage continues for the period of Furlough. Retroactive deductions are taken upon return to active employment.
Employee Assistance Program	Coverage continues for the period of Furlough.
Accident & Sickness Benefit Coverage	Coverage continues for the period of Furlough. If you become Totally Disabled while on Furlough, you may receive A&S benefits as long as unemployment compensation is not received.
Long-Term Disability Benefit Coverage	If enrolled, coverage continues for the period of Furlough. Retroactive deductions are taken upon return to active employment.
Basic Life Insurance Coverage, Basic AD&D Insurance Coverage, and Business Travel Accident Insurance Coverage	Coverage continues for the period of Furlough.
Additional/Supplemental Life Insurance Coverage	If enrolled, coverage continues for the period of Furlough. Retroactive deductions are taken upon return to active employment.
Group Universal Life	If enrolled, you may continue GUL directly through the GUL insurance carrier according to the provisions of that coverage. The GUL insurance carrier will bill you for the cost of your coverage.
Dependent Life Insurance Coverage	If enrolled, coverage continues for the period of Furlough. Retroactive deductions are taken upon return to active employment.
Personal Accident Insurance Coverage for Yourself and Your Dependents	If enrolled, coverage continues for the period of Furlough. Retroactive deductions are taken upon return to active employment.
Long-Term Care Insurance Coverage	If enrolled, you may continue Long-Term Care Insurance Coverage (LTC) directly through the LTC insurance carrier according to the provisions of that coverage. The LTC insurance carrier will bill you for the cost of your coverage.
Health Care and Day Care Spending Accounts	If enrolled, Spending Accounts continue for the period of Furlough. Retroactive deductions are taken upon return to active employment.

If You Are Laid-Off or Permanently Separated

You may receive certain benefits if you are an eligible employee who is Laid-off or Permanently Separated.

IMPORTANT NOTE: If you drop coverage for yourself, you can never re-enroll in coverage for any reason (including qualifying life events) at any time in the future. You must be enrolled in coverage for any Eligible Dependents to be enrolled in coverage.

	If you have less than 3 years of Eligibility Service	**If you have at least 3 years but less than 25 years Eligibility Service**	**If you have 25 or more years of Eligibility Service**
Medical Coverage	Coverage ends at midnight on your last day worked. You may continue coverage for yourself and your Eligible Dependents through COBRA, paying full COBRA rates until the COBRA continuation period expires.	Coverage ends at midnight on your last day worked. You may continue coverage for yourself and your Eligible Dependents through COBRA, paying active rates for the first (12) months; and full COBRA rates thereafter until the COBRA continuation period expires.	Through Company Continuation, if you are enrolled, coverage automatically continues for yourself and your Eligible Dependents if you pay the required contribution for this coverage in advance each month. The required contribution is determined by the Employer as a monthly amount that will equal the active rate for the first (12) months and thereafter will equal 50% of the Employer's total cost of coverage applicable for that year. The cost will change annually based on the estimated total cost of coverage for that Plan Year. Coverage for your dependent children may be continued while they remain eligible for coverage under the Plan. If you should die, your surviving Eligible Dependents may continue coverage according to Plan provisions by continuing to pay, in advance each month, the required contribution for the coverage elected. The required contribution for this coverage will be an amount that will equal the active rate for the first (12) months after the Layoff or Permanent Separation date and thereafter will equal 50% of the Employer's total cost of coverage that is applicable for that year. The cost will change annually based on the estimated total cost of coverage for that Plan Year. You may continue coverage for yourself until you are eligible for Medicare. Similarly, you may continue coverage for your spouse until your spouse is eligible for Medicare; however, after you become eligible for Medicare, you must continue to be enrolled in the Plan for your spouse to be eligible for coverage. When you or your spouse becomes eligible for Medicare, you may choose coverage for the Medicare-eligible individual under Special Programs with Medicare (SPM) by paying, in advance each month, the required contribution for coverage. The required

	If you have less than 3 years of Eligibility Service	If you have at least 3 years but less than 25 years Eligibility Service	If you have 25 or more years of Eligibility Service
			contribution is determined by the Employer as a monthly amount that will equal 50% of the Employer's total cost for the SPM coverage applicable for that year. The cost will change annually based on the estimated total cost of coverage for that Plan Year.
Dental Coverage	Coverage ends at midnight on your last day worked. You may continue coverage for yourself and your Eligible Dependents through COBRA paying full COBRA rates until the COBRA continuation period expires.	Coverage ends at midnight on your last day worked. You may continue coverage for yourself and your Eligible Dependents through COBRA paying active rates for the first (12) months; full COBRA rates thereafter until the COBRA continuation period expires.	
Employee Assistance Program	Coverage ends at midnight on your last day worked. You may continue coverage for yourself and your Eligible Dependents through COBRA paying full COBRA rates until the COBRA continuation period expires.		
Accident & Sickness Benefit Coverage and Long-Term Disability Benefit Coverage	Coverage ends at midnight on your last day worked.		
Basic Life Insurance Coverage	Coverage ends at midnight on your last day worked. You may apply for an individual converted life insurance policy if you apply to the insurance carrier and pay for the coverage within 31 days after coverage stops.	Coverage continues for (12) months. You may then apply for an individual policy if you apply to the insurance carrier and pay for the coverage within 31 days after coverage stops.	The full amount of coverage continues for (12) months. Your coverage further continues to your 62nd birthday at 75% of the amount in force on your last day worked with a maximum of $37,500 if you were a Salaried Employee and a maximum of $32,250 if you were an Hourly Employee. On your 62nd birthday, your coverage immediately reduces to $3,750 if you were a Salaried Employee or $3,225 if you were an Hourly Employee.
Basic AD&D Insurance Coverage	Coverage ends at midnight on your last day worked.	Coverage continues for (12) months.	
Business Travel Accident Insurance Coverage	Coverage ends at midnight on your last day worked.		

	If you have less than 3 years of Eligibility Service	If you have at least 3 years but less than 25 years Eligibility Service	If you have 25 or more years of Eligibility Service
Additional/ Supplemental Life Insurance Coverage	Coverage ends at midnight on your last day worked. You may apply for an individual converted life insurance policy if you apply to the insurance carrier and pay for the coverage within 31 days after coverage stops.	If enrolled, coverage continues for (12) months as long as you pay the required contributions in advance. You may then apply for an individual converted life insurance policy if you apply to the insurance carrier and pay for the coverage within 31 days after coverage stops.	
Group Universal Life	If enrolled, you may continue GUL directly through the GUL insurance carrier according to the provisions of that coverage. The GUL insurance carrier will bill you for the cost of your coverage.		
Dependent Life Insurance Coverage	Coverage ends at midnight on your last day worked. You may apply for an individual converted life insurance policy if you apply to the insurance carrier and pay for the coverage within 31 days after coverage stops.	If enrolled, coverage continues for (12) months as long as you pay the required contributions in advance. You may then apply for an individual converted life insurance policy if you apply to the insurance carrier and pay for the coverage within 31 days after coverage stops.	If enrolled, coverage continues as long as you have an Eligible Dependent by paying the required contribution in advance.
Personal Accident Insurance Coverage for Yourself and Your Dependents	Coverage ends at midnight on your last day worked.		
Long-Term Care Insurance Coverage	If enrolled, you may continue Long-Term Care Insurance Coverage (LTC) directly through the LTC insurance carrier according to the provisions of that coverage. The LTC insurance carrier will bill you for the cost of your coverage.		
Health Care Spending Account	If you participated in the Health Care Spending Account immediately prior to your Layoff or Permanent Separation, you may continue to contribute to your Account for the balance of the calendar year through COBRA. If you choose not to make further contributions through COBRA, you will only be able to submit claims for reimbursement of expenses that were incurred in the calendar year in which you were Laid-off or Permanently Separated, and which were incurred before your Layoff or Permanent Separation.		
Day Care Spending Account	No additional contributions to the Day Care Spending Account are permitted after you are Laid-off or Permanently Separated. You may continue to have access to your Account for eligible expenses (*i.e.*, expenses that you incurred to enable you and your spouse (if married) to work) incurred during the calendar year in which you were Laid-off or Permanently Separated, up to the balance remaining in your Account.		

Note: For any coverage that you are eligible to continue under COBRA, coverage will stop at midnight on your last day worked unless you timely elect and pay for COBRA coverage after you receive your COBRA notification from the COBRA Administrator. If you timely elect and pay for COBRA coverage, your coverage will be reinstated back to the termination date.

For Part-Time Employees, benefits after a Layoff or Permanent Separation are as described in the chart above except that:

- **Medical and dental coverage:** Coverage ends at midnight on your last day worked. You may continue coverage for yourself and your Eligible Dependents through COBRA, paying full COBRA rates until the COBRA continuation period expires.
- **Basic Life Insurance Coverage:** Coverage ends at midnight on your last day worked. You may apply for an individual converted life insurance policy if you apply to the insurance carrier and pay for the coverage within 31 days after coverage stops.
- **Basic Accidental Death & Dismemberment Insurance Coverage:** Coverage ends at midnight on your last day worked.

If You Work For a Successor Employer

This section contains summaries of the benefits provided in each benefit category if you are employed by a Successor Employer. COBRA will not be offered for any of the health care coverages unless coverage is not continued by the Successor Employer.

If You Have Less than 25 Years of Eligibility Service or You Are a Part-Time Employee

Your benefit coverages stop on the date that you are employed with the Successor Employer. Conversions are available for Basic Life and Additional/Supplemental Life Insurance Coverages. You may apply for an individual converted life insurance policy if you apply to the insurance carrier and pay for the coverage within 31 days after coverage stops. The amount eligible for conversion will be reduced by any amount of life insurance for which you become eligible under any other group policy within 31 days after termination of coverage.

IMPORTANT NOTE: If you drop coverage for yourself, you can never re-enroll in coverage for any reason at any time in the future. You must be enrolled in coverage for any Eligible Dependents to be enrolled in coverage.

If you have 25 or more years of Eligibility Service

Medical Coverage	Through Company Continuation, you may continue medical coverage for yourself and your Eligible Dependents if you elect Company Continuation and you pay, in advance each month, the required contribution for this coverage. The required contribution is determined by the Employer as a monthly amount that will equal 50% of the Employer's total cost of coverage applicable for that year. The cost will change annually based on the estimated total cost of coverage for that Plan Year. Coverage for your dependent children may be continued while they remain eligible for coverage under the Plan. If you should die, your surviving Eligible Dependents may continue coverage according to Plan provisions by continuing to pay, in advance each month, the required contribution for the coverage elected. The required contribution for this coverage will be an amount that will equal 50% of the Employer's total cost of coverage that is applicable for that year. The cost will change annually based on the estimated total cost of coverage for that Plan Year. You may continue coverage for yourself until you are eligible for Medicare. Similarly, you may continue coverage for your spouse until your spouse is eligible for Medicare; however, after you become eligible for Medicare, you must continue to be enrolled in the Plan for your spouse to be eligible for coverage. When you or your spouse becomes eligible for Medicare, you may choose coverage for the Medicare-eligible individual under Special Programs with Medicare (SPM) by paying, in advance each month, the required contribution for coverage. The required contribution is determined by the Employer as a monthly amount that will equal 50% of the Employer's total cost for the SPM coverage applicable for that year. The cost will change annually based on the estimated total cost of coverage for that Plan Year.

Dental Coverage, Employee Assistance Program, Accident & Sickness Benefit Coverage, Long-Term Disability Benefit Coverage, Basic AD&D Insurance Coverage, Personal Accident Insurance Coverage for Yourself and Your Dependents and Business Travel Accident Insurance Coverage	Coverage ends at midnight on the date that you are employed with the Successor Employer.
Basic Life Insurance Coverage	Coverage continues to your 62nd birthday at 75% of the amount in force on your last day worked with a maximum of $37,500 if you were a Salaried Employee and a maximum of $32,250 if you were an Hourly Employee. On your 62nd birthday, your coverage immediately reduces to $3,750 if you were a Salaried Employee or $3,225 if you were an Hourly Employee.
Additional/Supplemental Life Insurance Coverage	Coverage ends at midnight on the date that you are employed with the Successor Employer. You may apply for an individual converted life insurance policy if you apply to the insurance carrier and pay for the coverage within 31 days after coverage stops. The amount eligible for conversion will be reduced by any amount of life insurance for which you become eligible under any other group policy within 31 days after termination of coverage.
Group Universal Life	If enrolled, you may continue GUL directly through the GUL insurance carrier according to the provisions of that coverage. The GUL insurance carrier will bill you for the cost of your coverage.
Dependent Life Insurance Coverage	If enrolled, you may choose to continue coverage as long as you have an Eligible Dependent by paying the required contribution in advance.
Long-Term Care Insurance Coverage	If enrolled, you may continue Long-Term Care Insurance Coverage (LTC) directly through the LTC insurance carrier according to the provisions of that coverage. The LTC insurance carrier will bill you for the cost of your coverage.
Health Care Spending Account	No additional contributions to the Health Care Spending Account are permitted after you work for a Successor Employer. You continue to have access to your Account for eligible expenses incurred before the date you start to work for a Successor Employer, and in the same year that you start to work for a Successor Employer.
Day Care Spending Account	No additional contributions to the Day Care Spending Account are permitted after you work for a Successor Employer. You continue to have access to your Account for eligible expenses (i.e., expenses that you incurred to enable you and your spouse (if married) to work) incurred during the calendar year in which you start to work for a Successor Employer, up to the balance remaining in your Account.

If You Die While an Active Employee***

	If you did not meet the age and service requirements at the time of your death (see requirements to the right).	**If you were at least age 50 with at least 15 years of Eligibility Service; at least age 60 with at least 10 years of Eligibility Service; or any age with at least 25 years of Eligibility Service at the time of your death.** **If your survivors drop coverage, they can never re-enroll in coverage for any reason (including qualifying life events) at any time in the future.**
Medical and Dental Coverage	Coverage ends at midnight on the date of your death. Your Eligible Dependents may continue coverage through COBRA at no cost for the first (12) months; full COBRA rates thereafter until the COBRA continuation period expires.	If your Eligible Dependents were enrolled in coverage upon your death, their coverage automatically continues through Company Continuation, at no cost for the first (12) months, then 25% of the Employer's cost of coverage thereafter. Your spouse may continue coverage until the earlier of the date he/she becomes eligible for Medicare or remarries, and any other Eligible Dependents until they are no longer eligible.
Employee Assistance Program	Coverage ends at midnight on the date of your death. Your Eligible Dependents may continue coverage through COBRA paying full COBRA rates until the COBRA continuation period expires.	
Accident & Sickness Benefit Coverage and Long-Term Disability Benefit Coverage	Income benefit stops, if applicable.	
Basic Life Insurance Coverage, Basic AD&D Insurance Coverage, Business Travel Accident Insurance Coverage, Additional/Supplemental Life Insurance Coverage, and Personal Accident Insurance Coverage for Yourself	The Westinghouse Benefits Center will send your survivors the claim forms for these coverages, if applicable. Your survivors should follow the instructions to complete their part, then send the forms back to the Westinghouse Benefits Center. If your survivors have any questions on completing the claim forms, they should call the Westinghouse Benefits Center.	
Group Universal Life	If you were enrolled in Group Universal Life Insurance coverage, your survivors should call the GUL insurance carrier to request a claim form.	

Dependent Life Insurance Coverage	Company Continuation for (12) months by paying active rate. Conversion available when coverage ends.	If enrolled, your surviving spouse may continue coverage until the earlier of the date he/she becomes eligible for Medicare or the date he/she remarries by paying the required contribution in advance; surviving eligible dependent children may further continue coverage until they are no longer Eligible Dependents by paying the required contribution in advance. If coverage stops, your survivors may apply for an individual converted life insurance policy if they apply to the insurance carrier and pay for the coverage within 31 days after coverage stops.
Personal Accident Insurance Coverage for Your Dependents	Coverage ends at midnight on the date of your death.	
Long-Term Care Insurance Coverage	If your spouse is enrolled in Long-Term Care Insurance Coverage (LTC), your spouse may continue that coverage directly through the LTC insurance carrier according to the provisions of that coverage. The LTC insurance carrier will bill your spouse for the cost of coverage.	
Health Care Spending Account	If you participated in the Health Care Spending Account immediately prior to your death, Eligible Dependents may continue to contribute to this Account for the balance of the calendar year through COBRA. Your survivors may also choose to not make Health Care Spending Account contributions after your death. If your survivors choose not to make further contributions through COBRA, your survivors will only be able to submit claims for reimbursement of expenses that were incurred before the date of your death, and in the same calendar year as the date of your death.	
Day Care Spending Account	No additional contributions to the Day Care Spending Account are permitted after the date of your death. Your survivors may continue to have access to your Account for eligible expenses incurred during the calendar year in which your death occurred, up to the balance remaining in the Account.	

*****If a person on disability dies within the 2-year period from the last day he was at work, the survivor of active employee provisions set forth in the chart above will apply.**

Note: For any coverage that you are eligible to continue under COBRA, coverage will stop at midnight on your last day worked unless you timely elect and pay for COBRA coverage after you receive your COBRA notification from the COBRA Administrator. If you timely elect and pay for COBRA coverage, your coverage will be reinstated back to the termination date.

For Part-Time Employees, benefits if you die while an active employee are as described in the chart above except that:

- **Medical and dental coverage:** Coverage ends at midnight on your date of death. Your Eligible Dependents may continue coverage through COBRA at no cost for the first (3) months; full COBRA rates thereafter until the COBRA continuation period expires.

If You Retire

Please see Appendix N for information about health and welfare benefits in retirement.

Chapter 9 – Administration and Appeals

Administration

The Plan Administrator has all rights, duties and powers necessary or appropriate for the administration of the Plan, except to the extent that they are vested in the Appeals Authority in accordance with the appeal procedure described below.

Claims adjudication is not subject to the grievance process.

Claims Procedure

What is a Claim for Benefits?

For purposes of this section, a "claim for benefits" under the Plan is a request for a benefit made according to the Plan's reasonable procedures for filing benefit claims. **A request for a determination of whether you are eligible for benefits under the Plan is not a "claim for benefits."** However, if you or your Eligible Dependent file a claim for specific benefits and that claim is denied for lack of eligibility, the coverage determination is a claim for benefits and is subject to the claims and appeals procedures described below.

A "casual inquiry" about benefits or the circumstances under which benefits might be paid under the terms of the Plan is not a claim governed by the claims and appeals procedures described below.

A claim for benefits may be made by you or your Eligible Dependent. **For purposes of the Claims and Appeals Procedures described in this Chapter, the word "you" should be read to refer to whoever is filing the claim for benefits or appealing a denied claim – that is, you or, if applicable, your Eligible Dependent.**

Authorized Representative

You are entitled to have a representative act on your behalf when pursuing a benefit claim or appeal of an adverse benefit determination, if you choose to appoint a representative. For purposes of these claims and appeals procedures, the term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan.

To verify that a person is an authorized representative, you must submit to the Plan Administrator, Network Administrator, Spending Account Administrator or the insurance company, as appropriate, a letter that states the person is your duly authorized representative, and the scope of the representative's authority. That authorized representative's address must be included in the letter.

Once you have selected an authorized representative, the Plan Administrator, Network Administrator, Spending Account Administrator and/or the insurance company, as appropriate, will send all information and notifications to the authorized representative and not to you, unless you state otherwise in the letter appointing the authorized representative.

Notwithstanding the foregoing, if you are physically or mentally unable to designate an authorized representative, a health care professional with knowledge of your medical condition may act as your authorized representative in the case of an Urgent Health Care Claim.

You are solely responsible for any costs, fees, or charges of the authorized representative that may be incurred if you obtain an authorized representative. The Employer, Network Administrator, Spending Account Administrator and/or the insurance company will not pay any such costs, fees, or charges.

How to File a Claim

Please refer to Appendix L for information on how to file a claim.

Claim Determination Time Limits

For Claims Regarding:	Follow this procedure:
Plan Eligibility	If you have any questions about a denied eligibility claim, contact the Westinghouse Benefits Center for an additional explanation. If your eligibility claim is denied in whole or in part, you may file a final appeal of the eligibility claim by writing to the Plan Administrator, as described in the Appeals Procedure section of this Plan.
Self-Insured Medical Programs • Medical coverage • Mental health and substance abuse coverage • Prescription drug coverage • Vision coverage • Dental coverage • Health Care Spending Account • Employee Assistance Program	Please refer to Appendix K for the contact numbers and addresses of the Network Administrators and, for the Health Care Spending Account, the Spending Account Administrator. ***Urgent Health Care Claims.*** In the case of an Urgent Health Care Claim, you will be notified of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan. However, if you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, you will be notified as soon as possible (but not later than 24 hours after receipt of the claim by the Plan) of the specific information necessary to complete the claim. You will be given a reasonable amount of time (but not less than 48 hours) to provide the information required to complete the claim. If you were required to submit additional information, the determination of the Urgent Health Care Claim will be made within 48 hours of when the additional information is submitted. If you request an extension of a course of treatment beyond the time or number of treatments that have been approved, and the request involves an Urgent Health Care Claim, a decision will be made on the request as soon as possible, taking into account the medical exigencies. You will be notified of the Plan's benefit determination (whether adverse or not) within 24 hours after receipt of the claim by the Plan, provided that you make the request at least 24 hours before the scheduled termination of the treatment. ***Concurrent care decisions.*** You will be notified of any decision to reduce or terminate coverage of an ongoing treatment (other than by Plan amendment or termination) within a time frame that allows you to appeal such decision, and to obtain a determination of the appeal prior to the reduction or termination of coverage. ***Pre-Service Claims.*** You will be notified of the Plan's determination of a Pre-Service Claim within 15 days of the Plan's receipt of the claim. However, this period may be extended by 15 days if you are notified of the need for the extension within the initial 15-day period. If you fail to submit information necessary for the Plan to decide the claim, you will have 45 days from receipt of a notice of such failure to submit the required information. You will be notified within 5 days if you file an improper or incomplete Pre-

	Service Claim. The notice of the failure may be provided orally, unless you request written notification. ***Post-Service Claims***. You will be notified of the Plan's determination of a Post-Service Claim within 30 days of the Plan's receipt of the claim. However, this limit may be extended by 15 days if you are notified of the need for the extension within the initial 30-day period. If you fail to submit information necessary for the Plan to decide the claim, you will have 45 days from receipt of a notice of such failure to submit the required information.
Day Care Spending Account	Please refer to Appendix K for the contact number and address of the Spending Account Administrator. After you submit a claim in accordance with the claims procedures under Appendix L, the Spending Account Administrator will review your claim and notify you of its decision to approve or deny your claim. The Spending Account Administrator will generally notify you of its decision with respect to the claim within 90 days from the date the claim was submitted, unless the Spending Account Administrator determines that special circumstances require an extension of time for processing the claim. The Spending Account Administrator will notify you prior to the expiration of the initial 90-day period if it determines that an extension of time for processing the claim is required, state the reason why the extension is needed, and state when it will make its determination. If an extension is needed, the Spending Account Administrator will notify you of its decision with respect to the claim within 180 days from the date the claim was submitted. If the Spending Account Administrator denies a claim in whole or in part, the notification of the claims decision will state the reason why the claim was denied. If the claim is denied because the Spending Account Administrator did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. If you have any questions about a denied claim, contact the Spending Account Administrator for an additional explanation. If a claim is denied in whole or in part, you may file an appeal of the claim in writing to the Spending Account Administrator, as described below.
Fully-Insured Coverages • Accident & sickness benefit coverage • Long-term disability benefit coverage • Basic life insurance coverage • Basic accidental death & dismemberment insurance coverage • Business travel accident insurance coverage • Additional/supplemental life	Please refer to Appendix K for the contract numbers and addresses of the Insurance Carriers. After you submit a claim in accordance with the claims procedures under Appendix L, the insurance company will review your claim and notify you of its decision to approve or deny your claim. If your claim pertains to the accident & sickness benefit coverage or long-term disability benefit coverage, the insurance company will generally notify you of its decision with respect to your claim within 45 days from the date you submitted your claim. However, if the insurance company requires additional time to decide your claim because of matters beyond its control, the insurance company may take up to two (2) extensions of 30 days each to make its decision on your claim. If the insurance company needs an extension, it will notify you prior to expiration of the initial 45-day period (or prior to the expiration of the first 30-day extension period if a second 30-day extension period is needed), state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete

insurance coverage • Group Universal Life • Dependent life insurance coverage • Personal accident insurance coverage	claim, the time from the date of the insurance company's notice requesting further information does not count toward the period during which the insurance company is to notify you of its decision on your claim. You will have 45 days from the date of the insurance company's notice to provide the requested information to the insurance company. If a claim pertains to a fully-insured coverage other than accident and sickness benefit coverage or long-term disability benefit coverage, the insurance company will generally notify you of its decision with respect to the claim within 90 days from the date the claim was submitted, unless the insurance company determines that special circumstances require an extension of time for processing the claim. The insurance company will notify you prior to the expiration of the initial 90-day period if the insurance company determines that an extension of time for processing the claim is required, state the reason why the extension is needed, and state when it will make its determination. If an extension is needed, the insurance company will notify you of its decision with respect to the claim within 180 days from the date the claim was submitted. If the insurance company denies a claim in whole or in part, the notification of the claims decision will state the reason why the claim was denied. If the claim is denied because the insurance company did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. If you have any questions about a denied claim, contact the insurance carrier for an additional explanation. If a claim is denied in whole or in part, you may file an appeal of the claim in writing to the insurance carrier, as described below.

Calculating Time Periods

The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all of the information necessary to make a benefit determination on review accompanies the filing. In the case of a Pre-Service Claim, Post-Service Claim, accident & sickness benefit coverage or long-term disability benefit coverage, if a period of time is extended because you do not submit the information that is necessary to decide the claim, the period for making the benefit determination is suspended from the date on which the notice of the extension is sent to you until the date on which you respond to the request for additional information.

Manner and Content of Notice of Benefit Determination

The notice of an adverse benefit determination will be in writing and will contain:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and
- A description of the Plan's appeals procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action following an adverse determination on appeal.

In addition, in the case of an adverse benefit determination for a self-insured medical benefit, accident & sickness benefit coverage or long-term disability benefit coverage, the notice will include:

- A statement disclosing any internal rule, guideline, or protocol that was relied upon in making the adverse determination;
- If the adverse determination was based on medical necessity or experimental treatment, an explanation of the scientific or clinical judgment for the determination;
- In the case of an adverse determination regarding an Urgent Health Care Claim, an explanation of the expedited review process for such claims.

In the case of an adverse benefit determination concerning an Urgent Health Care Claim, the information described above may be provided to you orally within the prescribed time frame, provided that a written notification is furnished to you not later than 3 days after the oral notice.

Appeals Procedure

If a claim is denied and you disagree with the denial and want to pursue the matter, you must file an appeal in accordance with the procedures set forth below. You cannot take any other steps unless and until you have exhausted the appeal procedure. For example, if a claim is denied and you do not use the appeal procedure, the denial of the claim is conclusive and cannot be challenged, even in court.

For detailed information on how to file an appeal under the Plan, please see the procedures below. You will need to state the reasons why you disagree with the denial of your claim. You must do this within the specified time period after the claim was denied. The Appeals Authority needs complete, accurate information in order to decide your appeal. By making an appeal, you are authorizing the Appeals Authority to get additional, relevant information from any sources, including from the Employer.

You are entitled to see all documents, records or other information pertinent to your appeal. Just ask the Plan Administrator, Network Administrator, Spending Account Administrator or insurance company, as appropriate, at the address shown in Appendix K. Whether a document, record, or other information is relevant to a claim will be determined by considering the following: (1) whether it was relied upon in making the benefit determination; (2) whether it was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (3) whether it demonstrates compliance with the administrative processes and safeguards designed to ensure and to verify that the benefit claim determination was made in accordance with governing Plan documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated claimants; (4) whether it constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The Appeals Authority will perform a review that takes into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The Appeals Authority may, in its sole discretion, hold a hearing. The Appeals Authority will issue a written decision within the specified time period. The decision will explain the reasoning of the Appeals Authority and refer to the specific provisions of this Plan on which the decision is based. If no written decision is issued within the specified time frames, the claim shall be deemed denied on review.

Please keep in mind that the Appeals Authority has a duty under federal law to administer the Plan in accordance with its terms. The Appeals Authority does not have any authority to depart from the terms of the Plan, no matter how compelling the circumstances.

For Appeals Regarding:	Follow this procedure:
Plan Eligibility	*Appeals Authority: Plan Administrator* • Please refer to Appendix K for the address of the Plan Administrator. If you have any questions about a denied eligibility claim, contact the Westinghouse Benefits Center for an additional explanation. If your claim is denied in whole or in part, you may file a final appeal of the eligibility claim by writing to the Plan Administrator. This request must be submitted within 60 days of the date your claim was totally or partially denied. It should include any documents, records, questions, or comments necessary for a complete review. The Plan Administrator will review your request and notify you in writing of its final decision, the specific reasons for such decision, and specific references to Plan provisions. This decision will be made within 60 days after receiving your request, unless there are special circumstances. If there are special circumstances, you will be notified within 120 days. The Plan Administrator has the discretionary authority to interpret the terms and application of the Plan as they relate to your application for eligibility to participate in the Plan and to make a final determination of all claims. Its decision will be final and binding. If a claim relates to (1) a denial, reduction, or termination of a benefit, or (2) a failure to provide or make payment (in whole or in part) for a benefit, and any such denial, reduction, termination, or failure to provide or make payment is based on a determination of a participant's or beneficiary's eligibility to participate in the Plan, the Appeals provisions applicable for Self-Insured Coverage or Fully-Insured Coverage shall apply.
Self-Insured Medical Coverages • Medical coverage • Mental health and substance abuse coverage • Prescription drug coverage • Vision coverage • Dental coverage • Health Care Spending Account • Employee Assistance Program	*Appeals Authority:* • 1st Level: Network Administrator, <u>except</u> for the Health Care Spending Account; the Spending Account Administrator reviews the first appeal for the Health Care Spending Account. • Final Level: Plan Administrator, <u>except</u> for Medical coverage; the Network Administrator handles the final level appeal for Medical coverage. Please refer to Appendix K for the addresses of the Network Administrators, Spending Account Administrator and the Plan Administrator. **<u>Appeal of an Adverse Benefit Determination</u>** If your initial health claim is denied, you may appeal the denial within 180 days of your receipt of the written adverse benefit determination. You will be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim. You may, upon appeal, submit written comments, documents, records, and other information relating to the claim for benefits. A decision on review will be made: (i) as soon as possible following the Plan's receipt of the written request for review of an Urgent Health Care Claim, but not later than 72 hours after receipt of the claim; (ii) within a reasonable period of time following the Plan's receipt of the written request for review of a Pre-Service Claim, but not later than 15 days after receipt of the claim; and

	(iii) not later than 30 days following the Plan's receipt of the written request for review of a Post-Service Claim. If your initial appeal for a Pre-Service Claim or a Post-Service Claim is denied, you may appeal the denial of the initial appeal within 60 days of your receipt of the written adverse benefit determination. In that case, the decision on review will be made (i) within a reasonable period of time following the Plan's receipt of the second written request for review of a Pre-Service Claim, but not later than 15 days after receipt of the claim; and (ii) 30 days following the Plan's receipt of the second written request for review of a Post-Service Claim. The review of an appeal of a denied claim will be made by a person different from the person who made the initial determination (or, in the case of a second appeal, by a different person from the person who decided the initial appeal) and will not grant deference to the initial denial (or, in the case of a second appeal, to the initial denial or initial appeal). The decision maker will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of medical judgment, a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment will be consulted. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate of that person (or, in the case of a second appeal, will not be the individual consulted during the initial determination or initial appeal, or a subordinate of that person).
Day Care Spending Account	*Appeals Authority:* • 1st Level: Spending Account Administrator • Final Level: Plan Administrator Please refer to Appendix K for the addresses of the Spending Account Administrator and the Plan Administrator. If your claim is denied in whole or in part, you may file an appeal of the claim in writing to the Spending Account Administrator. State why you think your claim should be granted, and include any documents, records, questions, or comments you think are necessary or will aid in a complete review. Upon written request, the Spending Account Administrator will provide you with copies of documents, records and other information relevant to your claim. Your review request must be made within 180 days of the date your claim was totally or partially denied. The Spending Account Administrator will notify you of its decision within 60 days after receiving your appeal, unless it determines that special circumstances require an extension of time for deciding the appeal. The Spending Account Administrator will notify you if special circumstances require an extension of time for deciding the appeal, state the reason why the extension is needed, and state when it will make its determination with respect to the appeal. If an extension is needed, the Spending Account Administrator will notify you of its decision with respect to your claim within 120 days from the date you submitted your appeal. If your claim is denied on appeal, you may appeal the denial of the initial appeal to the Plan Administrator, provided that you do so within 60 days of denial of the initial appeal. The Plan Administrator will notify you of its decision within 60 days after receiving your appeal, unless the Plan

	Administrator determines that special circumstances require an extension of time for deciding the appeal. The Plan Administrator will notify you if special circumstances require an extension of time for deciding the appeal, state the reason why the extension is needed, and state when it will make its determination with respect to the appeal. If an extension is needed, the Plan Administrator will notify you of its decision with respect to your claim within 120 days from the date you submitted your appeal.
Fully-Insured Coverages • Accident & sickness benefit coverage • Long-term disability benefit coverage • Basic life insurance coverage • Basic accidental death & dismemberment insurance coverage • Business travel accident insurance coverage • Additional/supplemental life insurance coverage • Group Universal Life • Dependent life insurance coverage • Personal accident insurance coverage	*Appeals Authority: Insurance Carrier* • Please refer to Appendix K for the contract numbers and addresses of the Insurance Carriers. If your claim is denied in whole or in part, you may file an appeal of the claim in writing to the insurance carrier. State why you think your claim should be granted, and include any documents, records, questions, or comments you think are necessary or will aid in a complete review. Upon written request, the insurance company will provide you with copies of documents, records and other information relevant to your claim. If your appeal pertains to the accident & sickness benefit coverage or long-term disability benefit coverage, your review request must be made within 180 days of the date your claim was totally or partially denied. If your claim pertains to a fully-insured coverage other than accident and sickness benefit coverage or long-term disability benefit coverage, your review request must be made within 60 days of the date your claim was totally or partially denied. After the insurance company receives your written request appealing the initial determination, the insurance company will conduct a full and fair review of your claim. If your appeal of a denied claim pertains to accident and sickness benefit coverage or long-term disability benefit coverage, the insurance carrier will not grant deference to the initial denial. The person who will review your claim will not be the same person as the person who made the initial decision to deny your claim. If the initial decision is based in whole or in part on a medical judgment, the insurance company will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. The insurance company will generally notify you of its decision with respect to your appeal within 45 days from the date you submitted your appeal. However, if the insurance company requires additional time to decide your appeal because of special circumstances, the insurance company may take a 45-day extension to make its decision on your appeal. If the insurance company needs such extension, it will notify you prior to the expiration of the initial 45-day period, state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from the insurance company's notice to you of the need for an extension to when the insurance company receives the requested information does not count toward the time the insurance company is allowed to notify you of its decision. You will have 45 days from the date of the insurance company's notice to provide the requested information to the insurance company. If your appeal of a denied claim pertains to a fully-insured coverage other than accident and sickness benefit coverage or long-term disability benefit

	coverage, the insurance carrier will notify you of its decision within 60 days after receiving your appeal, unless the insurance company determines that special circumstances require an extension of time for deciding the appeal. The insurance carrier will notify you if special circumstances require an extension of time for deciding the appeal, state the reason why the extension is needed, and state when it will make its determination with respect to the appeal. If an extension is needed, the insurance company will notify you of its decision with respect to your claim within 120 days from the date you submitted your appeal. The insurance carrier has the discretionary authority to interpret the terms and application of the Plan as they relate to your application for benefits and to make a final determination of all claims. Its decision will be final and binding. Your beneficiary should follow these same instructions to appeal a claim that follows your death.

Calculating Time Periods

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed, without regard to whether all of the information necessary to make a benefit determination on review accompanies the filing. In the case of appeals regarding Plan Eligibility, or regarding the Day Care Spending Account or any insured coverage, if a period of time is extended because you do not submit the information that is necessary to decide the claim, the period for making the benefit determination on review will be tolled from the date on which the notice of the extension is sent to you until the date on which you respond to the request for additional information.

Notice of Benefit Determination on Appeal

A notice of the benefit determination following the appeal will be in writing. If an appeal is denied, in whole or in part, the notice will contain the following information:

- The specific reason(s) for the determination;
- A reference to the specific Plan provision(s) on which the determination is based;
- A statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and
- A statement that the individual has the right to bring an action under section 502(a) of ERISA.

In addition, in the case of an adverse appeal determination for a self-insured medical benefit, accident & sickness benefit coverage or long-term disability benefit coverage, the notice will include:

- A statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- If the adverse determination was based on medical necessity or experimental treatment, an explanation of the scientific or clinical judgment for the determination; and
- The identity of any medical or vocational experts whose advice was obtained in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the adverse benefit determination.

Discretionary Authority

The Plan Administrator or, as applicable, the Appeals Authority, shall have and shall exercise complete discretionary authority to construe, interpret and apply all of the terms of the Plan, including all matters relating to eligibility for benefits, amount, time or form of payment, and any disputed or allegedly doubtful terms. In other words, benefits will be paid only if the Plan Administrator or applicable Appeals Authority listed above decides, in its discretion, that the applicant is entitled to benefits. Similarly, eligibility for benefits will be granted only if the Plan Administrator decides, in its discretion, that the applicant is eligible to participate with respect to the particular benefits. In exercising such discretion, the Plan Administrator and Appeals Authority shall give controlling weight to the intent of the sponsor of the Plan.

All decisions of the Plan Administrator or Appeals Authority in the exercise of its authority under the Plan shall be final and binding on the Plan, the Plan sponsor and all participants and beneficiaries.

Changing or Ending the Plan

- **Changing the Plan**. Westinghouse has the right to change the Plan in any way and at any time and is not required to give a reason for the changes. These changes can be retroactive. Any special arrangement made by Westinghouse for an individual will only be applicable to that individual. Westinghouse's right to change the Plan may be exercised by Westinghouse's Vice President for Human Resources or Chief Financial Officer by appropriate written action, and, with respect to changes that do not materially increase costs or materially change participants' benefits, may be exercised by Westinghouse's Director, Compensation and Benefits, by appropriate written action.

- **Ending the Plan**. Although Westinghouse intends to maintain the Plan indefinitely, Westinghouse reserves the right to end the Plan (in whole or in part) at any time and is not required to give a reason for doing so. Westinghouse's Board of Directors must approve any amendment that terminates the Plan. The benefits under this Plan are not vested.

If Westinghouse ceases to pay premiums on an insurance contract, that coverage of the Plan terminates automatically, without further action by Westinghouse, as of the close of the last period for which the premium was paid in full.

Network Administrators, Insurance Carriers, and Vendors

The Plan Administrator is empowered to change Network Administrators, insurance carriers and/or vendors.

Collective Bargaining Agreements

This Plan is covered by collective bargaining agreements for employees covered by those agreements. You may examine a copy of any agreement that applies to you at your local Human Resources office. You may obtain a copy of the agreement by writing to your local Human Resources representative. You will be charged for copies of any documents you request.

A complete list of unions participating in this Plan is also available from the Plan Administrator.

Examinations

The Employer has the right and opportunity through its medical representative to examine any person when and so often as it may reasonably require while a disability claim is pending under the Plan.

How To Get Plan Legal Documents

You or your beneficiary may examine any or all legal documents at the principal office of the Plan Administrator or at your local Human Resources office. Upon written request to the Plan Administrator, a copy of legal documents will be sent to any participant or beneficiary. The administrator may make a reasonable charge for the copies.

Use and Disclosure of Protected Health Information

The Plan will use protected health information (PHI) to the extent and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Privacy Rule. For purposes of this section of the Plan, the term "Plan" refers only to the medical, dental, vision, employee assistance program and Health Care Spending Account portions of the Plan.

The Plan will Use and Disclose PHI for purposes related to Payment, Health Care Operations and the other purposes described in the Plan's Privacy Notice. A copy of the Plan's Privacy Notice is included as Appendix P and is also incorporated by reference in this section of the Plan document.

The Plan will also Disclose PHI to the Employer in certain instances as described in greater detail, below.

Definitions

The following special definitions apply only for purposes of this section:

- ***Disclose, Disclosing or Disclosure*** means the release, transfer, provision of access to, or divulging in any other manner of PHI.
- ***Health Care Operations*** include, but are not limited to, the following activities:
    - quality assessment;
    - underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
    - conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
    - business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan; and
    - business management and general administrative activities of the Plan, including, but not limited to:
        - management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, and
        - customer service, including the provision of data analyses for the Employer.
- ***Individual*** means the person who is the subject of the PHI, and shall include a person who qualifies as a personal representative in accordance with the Privacy Rule.
- ***Payment*** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and Co-payments as determined for an individual's claim);
- coordination of benefits;
- adjudication of health benefit claims (including appeals and other payment disputes);
- subrogation of health benefit claims;
- establishing employee contributions;
- billing, collection activities and related health care data processing;
- claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- medical necessity reviews or reviews of appropriateness of care or justification of charges;
- utilization review, including precertification, preauthorization, concurrent review and retrospective review; and
- Disclosure to consumer reporting agencies of the Individual's name and address, date of birth, Social Security number, payment history, account number, and name and address of the Plan, but solely for purposes related to obtaining reimbursement for the Plan of any amount the Individual owes the Plan.

- ***Privacy Rule*** means the *Final Rules on Standards for Privacy of Individually Identifiable Health Information* set forth in Federal regulations at 45 CFR Part 160 and Part 164, Subparts A and E.
- ***Protected Health Information*** or ***PHI*** is information (including demographic information collected from an Individual) that is transmitted or maintained in any form or medium (i.e., electronic, written or oral) that:
  - relates to the past, present or future physical or mental health or condition of an Individual; the provision of health care to an Individual; or the past, present or future payment for the provision of health care to an Individual;
  - is created by a health care provider, health plan, employer, or health care clearinghouse; and
  - identifies the Individual, or there is a reasonable basis to believe that the information can be used to identify the Individual.
- ***Required by Law*** means a mandate contained in law that compels an entity to Use or Disclose PHI and that is enforceable in a court of law. The phrase "Required by Law" includes, but is not limited to: court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.
- ***Secretary*** means the Secretary of the U.S. Department of Health and Human Services or designee.
- ***Summary Health Information*** means information:

- that summarizes the claims history, claims expenses, or type of claims experienced by Individuals for whom the Employer has provided health benefits under a group health plan; and

- from which the information described at 45 CFR section 164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR section 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

- ***Use*** means the sharing, employment, application, utilization, examination, analysis, de-identification, or commingling with other information, of information by a party that holds that information.

Disclosure of PHI to the Employer

This section describes the situations in which the Plan may Disclose PHI to the Employer.

- The Plan may Disclose an Individual's PHI to the Employer pursuant to the Individual's authorization. For example, if an Individual asks his or her local human resources representative and/or advocacy service for assistance in obtaining benefits under the Plan, the Individual must complete and sign an authorization before the Plan will Disclose the Individual's PHI to the human resources representative and/or advocacy service; if the Individual does not sign an authorization in this situation, the Plan will not be able to Disclose any of the Individual's PHI to the human resources representative and/or advocacy service. In that case, the human resources representative and/or advocacy service may not be able to provide the Individual with effective assistance. Similarly, if a person seeks assistance from a human resources representative and/or advocacy service regarding another Individual, the Individual must appoint the person as his or her personal representative; if, for example an employee seeks assistance in obtaining benefits under the Plan for his or her spouse, the spouse must designate the employee as his or her personal representative before the employee will be given access to the spouse's PHI or allowed to take any action for the spouse.

- The Plan may Disclose an Individual's PHI to the Employer as Required by Law.

- The Plan may Disclose to the Employer whether an Individual is participating in (or has stopped participating in) the Plan. This information may be needed to determine the employee contributions (if any) that are withheld from an employee's pay to pay for the benefits that are provided under the Plan.

- The Plan may Disclose PHI to the Employer for purposes related to Payment or Health Care Operations, or for any such other purpose described in the Plan's Privacy Notice (which is set forth in Appendix P). These Disclosures may be necessary because employees of the Employer perform many of the administrative functions necessary for the management and operation of the Plan, such as conducting cost-management and planning-related analyses for the Employer regarding the Plan.

- The Plan may Disclose Summary Health Information to the Employer. The Employer must limit its use of that information to: (i) obtaining quotes from insurers, third-party administrators and other plan providers; or (ii) modifying, amending or terminating the Plan.

For purposes of the last three bullet points listed above, only the following employees or classes of employees may be given access to PHI (i) the Compensation and Benefits Health & Welfare Benefits Staff of the Employer; (ii) the Plan Sponsor's Director of Compensation and Benefits; (iii) human resources representatives of the Employer as named on the Benefits Center contact list; and (iv) members of the Employer's Accounting Department who are responsible for allocating the cost for group health benefits for Individuals terminated as part of a Layoff to individual business units of the Employer. The person who holds any position described in the previous sentence may only have access to, and Use

and Disclose PHI, to the extent that the person performs management or administrative functions for the Employer that are related to the Plan.

The Plan Sponsor has certified to the Plan that the Plan's terms have been amended (pursuant to these provisions) to reflect the above-described restrictions on the Use and Disclosure of PHI.

Employer Conditions with Regard to PHI

The Employer agrees that, with respect to any PHI Disclosed to the Employer by the Plan, that the Employer will:

- not Use or further Disclose PHI, other than as permitted or required by the Plan document or as Required by Law;
- ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;
- not Use or Disclose PHI for employment-related actions and decisions unless authorized by an Individual;
- not Use or Disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by an Individual;
- report to the Plan any Use or Disclosure of PHI that is inconsistent with the Uses or Disclosures provided for in this Plan document of which it becomes aware;
- make PHI available to an Individual in accordance with the Privacy Rule's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Rule;
- make available the information required to provide an accounting of Disclosures in accordance with the Privacy Rule;
- make internal practices, books and records relating to the Use and Disclosure of PHI received from Plan available to the Secretary for the purposes of determining the Plan's compliance with the Privacy Rule; and
- if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form, and retain no copies of that PHI when no longer needed for the purpose for which Disclosure was made (or if return or destruction is not feasible, limit further Uses and Disclosures to those purposes that make the return or destruction infeasible).

Noncompliance Issues

The Employer has developed a mechanism for resolving issues of noncompliance, including disciplinary sanctions, if the persons described above in the section captioned "Use and Disclosure of PHI to the Employer" make an impermissible Use or Disclosure of PHI. Any failure to comply with the policies and procedures described in this Plan document for handling PHI is a violation of Westinghouse policies and procedures and Westinghouse's Standards of Conduct. As set forth in Westinghouse's Standards of Conduct, such behavior may result in disciplinary action, up to and including discharge. In addition, impermissible Use or Disclosure of PHI may result in the imposition of civil and/or criminal penalties under the Privacy Rule. The Employer will take any necessary steps to mitigate any harmful effects to the affected Individual resulting from the Employer's improper Use or Disclosure of PHI.

If you believe the Plan or the Employer has violated your privacy rights with respect to your PHI, you may file a complaint with the Plan's Privacy Officer, James A. Buddie, Westinghouse Electric Company, 4350 Northern Pike, Monroeville, PA 15146. The Plan will not penalize you for filing a complaint. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services.

Chapter 10 – Miscellaneous and Statement of ERISA Rights

Miscellaneous

Qualified Medical Child Support Orders (QMCSO)

If the Westinghouse Benefits Center receives a child support order that is (i) a judgment, decree or order of a court (including approval of a settlement agreement) (or else issued through an administrative process established under state law that has the force and effect of law under applicable state law), that (ii) provides for child support for a child of an eligible employee and (iii) either relates to benefits under the health care coverages of the Plan or enforces a federally prescribed state law relating to Medicaid recipients, then the Westinghouse Benefits Center will notify you and the child that the order has been received and describe the procedure that the Westinghouse Benefits Center will follow in deciding whether to honor the order.

Next, the Westinghouse Benefits Center will separately account for health care claims filed that, in the absence of the order, would not be paid. Payment of these claims will be neither approved nor denied while the Westinghouse Benefits Center decides whether to honor the order.

The Plan will not honor a child support order unless it constitutes a "Qualified Medical Child Support Order" under the law. That means the Plan will not honor a child support order unless it specifies:

- that it applies to this Plan;
- the name and last known mailing address of the affected employee;
- the name and last known mailing address of the child;
- a reasonable description of the type of coverage to be provided by the Plan to each child or the manner in which the coverage is to be determined; and
- the time period to which the order applies.

Also, the Plan will not honor a child support order that purports to require the Plan to provide any type or form of benefit, or any option, that is not already provided for in the Plan (except as necessary to satisfy a federally prescribed state law relating to Medicaid recipients).

Upon making the decision whether the order is a "Qualified Medical Child Support Order" under the law, the Westinghouse Benefits Center will notify the employee and the child and act in accordance with the decision.

Family and Medical Leave

While on a Leave of Absence to which you are entitled under the federal Family and Medical Leave Act of 1993, you will not suffer the loss of any "employment benefit" (as defined for the purpose of the Family and Medical Leave Act) under any feature of the Plan which had accrued before you took the leave and which would not have been lost if you had remained actively at work. But you will not accrue any additional "employment benefits" under any feature of the Plan during the leave, except as specifically set forth in any particular feature.

Military Service

Upon re-employment in accordance with the federal Uniformed Services Employment and Reemployment Rights Act of 1994 (which has rules about honorable discharge and time limits on returning to work), you regain entitlement to all rights and benefits which are determined by length of service that you had under the Plan when the military service began, plus any additional such rights and benefits that you would have accrued if you had remained continuously employed during the military service.

In addition, no exclusion or Waiting Period will be applied under any health feature of the Plan that would not have been applied if you had remained continuously employed, except with respect to an illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

Maternity

The medical coverage feature of the Plan will comply with the Newborns' and Mothers' Health Protection Act of 1996. In that regard, government regulations also require us to provide this statement: “Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).”

Women's Health and Cancer

The medical coverage feature of the Plan will make available coverage for (a) reconstruction of the breast on which the mastectomy has been performed, (b) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (c) prostheses and physical complications at all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. The coverage may be subject to annual Deductibles and Co-payment provisions consistent with other benefits under the Plan.

Utilization Test

With regard to those features of the Plan that constitute a “cafeteria” plan, while the Plan makes the same benefits available to all eligible employees, regardless of the level of their compensation, it is possible for the top-level employees to actually take advantage of those features to a significantly greater extent than other employees. In that case (which we see as highly unlikely), the Internal Revenue Code denies the tax advantage to these top-level employees. (Everyone else still enjoys the full tax advantage.) The Plan Administrator will monitor this situation and notify any top-level employee who is affected by it. The Plan Administrator also has authority to cut back the utilization of top-level employees in order to avoid the problem.

Service of Process

Service of legal process may be made on the Plan Administrator.

Employer Identification Number and Plan Number

The Employer Identification Number (EIN) assigned by the Internal Revenue Service to Westinghouse is 82-0508469.

The Plan Number assigned to the Plan is 501.

Type of Plan

The Plan is a welfare benefits plan. The Plan's components include medical coverage (which includes mental health and substance abuse treatment, prescription drug and vision coverage), dental coverage, the Health Care Spending Account, the Employee Assistance Program, Accident & Sickness benefit coverage, long-term disability benefit coverage, basic life insurance coverage, additional/supplemental life insurance coverage, dependent life insurance coverage, basic accidental death and dismemberment insurance coverage (AD&D), business travel accident insurance coverage, personal accident insurance coverage for yourself and your family, the Day Care Spending Account, and Long-Term Care insurance coverage.

Plan Administrator and Administration of Plan

Contact information for the Plan Administrator, and information about how the Plan is administered, can be found in the Introduction to the Plan, under the caption "Administrator," and in Appendix K.

Circumstances Which May Affect Benefits

Circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of any benefits are listed in the relevant portions of the Plan (including the Appendices) with respect to the various benefits provided under the Plan. Descriptions of these circumstances may be found in the following sections of the Plan, among other sections: Chapter 1, under the captions "When Your Participation Ends," and "When Your Dependent's Participation Ends"; Chapter 2, under the captions "Separation from Service" and "Failure to Make Required Contributions"; Chapter 4, under the captions "Health Care Spending Account – When Your Employment Terminates" and "Continued Coverage Under COBRA"; Chapter 8 in its entirety; Chapter 9, under the caption "Changing or Ending the Plan", and in the insurance booklets with respect to any fully-insured coverage.

Finally, if the Plan Administrator, Network Administrator, Spending Account Administrator or Insurance Company determines that you or any dependent have attempted to obtain benefits, or obtained benefits, under the Plan fraudulently, participation in the Plan may be terminated for (i) the individual who committed or attempted to commit the fraud, and (ii) for any individual who assisted such individual to commit, or to attempt to commit, such fraud.

Source of Plan Contributions

The Contributions to the Plan are made by the Employers from their general assets, as well as from After-Tax Contributions by the Plan's participants and beneficiaries.

Funding Medium for Providing Benefits

The Plan is financed by contributions from the Employer's general assets, including from Pre-Tax Contributions made by participants, and from After-Tax Contributions made by participants and beneficiaries. Some of these contributions are applied toward insurance contracts that provide benefits under the Plan. Information about the insurance contracts for the fully-insured portions of the Plan may be found in Appendix K. Benefits for the self-insured portions of the Plan are paid from the Employer's general assets.

End of Plan Year

The date of the end of the Plan Year for purposes of maintaining the Plan's fiscal records is December 31.

Statement of ERISA Rights

As a participant in the Westinghouse Government Services Group, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part (and you have exhausted the Plan's internal appeal procedure), you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person

you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U. S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Appendix A – Participating Employers

The following are Participating Employers under this Plan:

- Westinghouse Government Services Company, LLC
- Westinghouse Government Environmental Services Company, LLC

Appendix B – Definitions

Administrative Committee

The person(s) appointed by Westinghouse by written action of the Board of Directors of Westinghouse or its delegate, who are the "named fiduciaries" of the Plan, within the meaning of Section 402 (a)(2) of ERISA, with respect to Plan administrative matters.

After-Tax Contributions

Pay dollars from which federal and state income taxes and Social Security taxes have already been deducted.

Allowable Amount; Allowable Expense; Allowance

The highest amount the Network Administrator will pay for a specific Covered Service. The amount is based on the Usual, Customary and Reasonable fee for such service (see Usual, Customary, and Reasonable (UCR) Charges).

Annual Maximum

The most the coverage will pay for Covered Services in the calendar year your benefit elections are in effect.

Appeals Authority

The Plan Administrator or insurance carrier, as described in Chapter 9 and specified in Appendix K, that has the authority to grant or deny an appeal of a claim arising under the Plan.

Balance Billing

When a provider bills the patient for the difference between his/her usual fee and the Allowance.

Benefit Pay

Benefit Pay is the base pay as of September 1 of the year prior to the year for which you are enrolling. For Salaried Employees, Benefit Pay is the monthly base rate as of September 1 times 12 months. For Hourly Employees, Benefit Pay is the base hourly rate as of September 1 times 2,080 hours. For new hires, Benefit Pay is the base pay on the date of hire.

- Salaried Base Pay: Base pay, excluding bonus and incentives.
- Hourly Base Pay: Annualized hourly rate, excluding bonuses, incentives, shift differentials and overtime.

Benefit Pay will not change during the Plan Year even if pay changes, except if an employee moves from part-time employment to full-time employment, or vice versa.

If the rate of record which would have been used for vacation pay when you were last actively at work is higher than your Benefit Pay, benefits payable under the Accident & Sickness Benefit Coverage and Long-Term Disability Benefit Coverage are based on the higher amount.

Benefit Period

A Benefit Period, applicable to the hospital program under Special Programs with Medicare, means a period of consecutive days beginning with the first day (not included in a previous Benefit Period) on which you or your spouse receive inpatient hospital services. It ends with the close of the first period of 60 consecutive days thereafter, on each of which you or your spouse are not an inpatient of a hospital or skilled nursing facility.

Benefits Connection

The interactive phone system that connects participants to the Westinghouse Benefits Center as well as benefits Network Administrators, insurance carriers and vendors. The toll-free phone number for Benefits Connection is 1-800-890-3600.

Billing Administrator; Direct Billing Administrator

The company, currently HM Benefits Administrators, Inc., designated by the Plan Administrator to fulfill the direct billing administrative functions of the Plan.

Casual Employee

An employee who is hired either:

- for a predetermined limited period of time, usually not longer than two or three months; or,
- for the purpose of completing a specific task that is anticipated not to exceed five months, and who has no expectation of continued employment beyond completion of that task.

The determination of who is a Casual Employee shall be made on a uniform and nondiscriminatory basis.

Casual Employees include summer students, interns, and co-op students who alternate periods of full-time employment with periods of full-time study.

COBRA Administrator

The company, currently HM Benefits Administrators, Inc., designated by the Plan Administrator to fulfill the COBRA administrative functions of the Plan.

Code

The Internal Revenue Code of 1986, as amended from time to time.

Company Continuation

Continuation of certain benefits, if you are enrolled at the time of an event, until you reach the maximum continuation period allowed under Plan provisions. An employee who elected No Coverage for a Plan Year cannot continue coverage at the time of an event because there is no coverage to continue.

Compensation and Benefits Staff

Those Westinghouse employees whose job functions include the day-to-day management of the Plan.

Confirmation Statement

An on-line or printed report of your health and welfare benefit elections under the Plan which shows the benefit options selected and the cost for those selections.

ConnectBenefits On-Line

The Web-based system that is a portal to the Web sites of the Westinghouse Benefits Center as well as benefits Network Administrators, insurance carriers and vendors. The Web site address for *ConnectBenefits On-Line* is www.mybenefitsdirectory.com/westinghouse.

Co-payment

The coverage pays a percentage of the Allowable Amount of Covered Expenses, after the Deductible, if any, is satisfied. The amount you pay, up to the annual Out-of-Pocket Maximum, is called your Co-payment. For example, if medical coverage pays 80% of Covered Expenses after the Deductible is satisfied, the employee's share will be equal to the remaining 20% of Covered Expenses, until the employee reaches the annual Out-of-Pocket Maximum. Co-payment also includes the $15 in-network physician office visit charge and the $25 emergency room visit charge, although these office visit or emergency room visit Co-payments do not apply to your Deductible or annual Out-of-Pocket Maximum. You are still responsible for paying the $15 in-network physician office visit Co-payment, the $25 emergency room visit Co-payment, and your Co-payments under mental health and substance abuse treatment, prescription drug and vision coverage even after your medical coverage Out-of-Pocket Maximum is met.

Coverage Category; Coverage Level

The number of people included under your coverages. Coverage categories include Employee-Only, Employee Plus One Dependent, and Employee Plus Two or More Dependents.

Covered Expenses; Covered Services

Those services or supplies eligible for payment under the coverage you have selected. Please note, however, that even if a service is covered, it may not be covered at 100% (see Co-payment), or it may not be paid for if you have not yet met your Deductible (see Deductible), or it may be covered at a Usual, Customary and Reasonable level (see Usual, Customary and Reasonable (UCR) Charges).

Deductible

The amount you are required to pay each year before payments are made by the medical coverage options for Covered Services. The amount credited to the Deductible is the actual charge or the amount that the Network Administrator determines is the Usual, Customary, and Reasonable Charge for a service or product. See Appendix C for Deductible amounts under the medical coverage. The $15 in-network office visit Co-payment, the $25 emergency room visit Co-payment, and any out-of-pocket expenses that you pay for mental health and substance abuse treatment, prescription drug or vision coverage do not apply toward the Deductible.

Eligibility Service

Your service credit used to determine your eligibility for pension benefits. It includes service for periods of employment after age 65.

Eligible Dependents

Dependents eligible for medical coverage, dental coverage, Dependent Life Insurance Coverage, and Personal Accident Insurance Coverage include:

1. Your spouse, and

2. Your unmarried children under age 21 who totally depend on you for support. Dependent children age 19 and older who work full-time cannot receive benefits.

   Dependent children may continue to be covered beyond their 21st birthday if, in addition to the above, they are:

   - full-time students in a recognized course of study or training, up to their 25th birthday, not covered by any other group benefits plan (except student coverage) and classified as a full-time student by the educational institution in which the student is enrolled; or

   - (1) unable to support themselves because of a Total and Permanent Disability (a) that began before their 19th birthday if the dependent child worked in full-time employment after their 19th birthday, or (b) that began before their 21st birthday if the dependent child did not engage in full-time employment after their 19th birthday, or (c) that began before their 25th birthday if the dependent child was covered as a full-time student dependent under the Plan on the date the Total and Permanent Disability began, and (2) are enrolled in the Plan's coverage on the date the Total and Permanent Disability began. A disabled dependent child must be continually covered; if coverage stops for any reason, the child cannot be enrolled as a disabled dependent again unless the child otherwise meets the definition of an eligible dependent. The medical Network Administrator makes the disability certification determination and the certification period (the maximum certification period is five years) is based on the medical information that you submit on behalf of your dependent child.

Your children include:

- your own children;
- legally adopted children;
- children placed with you for adoption;
- stepchildren living with you;
- children supported only by you and living permanently in your household; and
- dependents who are eligible as a result of a Qualified Medical Child Support Order (QMCSO). See QMCSO definition in this Appendix. You will be notified if the medical child support order that is submitted is qualified.

A "spouse" refers only to a person of the opposite sex who is a husband or a wife. The Plan Administrator has the discretion to determine whether a person is a spouse for purposes of the Welfare Benefits Plan.

Your spouse is the only eligible dependent under Special Programs with Medicare coverage.

Dependents do not include:

- Any person, whether related to you or not, who resides outside of the United States or Canada; and

- Any person not specified in the definition of dependents.

Employee-Only Coverage

Medical and/or dental Coverage Category that provides benefits for you, the employee, only. This coverage does not provide benefits for your dependents.

Employee Plus One Dependent

Medical and/or dental Coverage Category that provides benefits for you and one Eligible Dependent.

Employee Plus Two or More Dependents

Medical and/or dental Coverage Category that provides benefits for you and two or more Eligible Dependents.

Employer, Participating Employer

Westinghouse Government Services Group or any subsidiary or affiliate that, by action of its Board of Directors and with the approval of the Board of Directors of Westinghouse, adopts this Plan, as specified in Appendix A to the Plan.

Enrollment Notice

The Notice that you receive with your new hire / newly eligible enrollment kit that contains the date by which you need to enroll.

ERISA

The Employee Retirement Income Security Act of 1974, as amended from time to time.

Excluded Unit

An employer that is a subsidiary or affiliate of an Employer but that does not participate in the Plan. PCI Energy Services is an Excluded Unit.

Experimental/Investigative

Experimental/Investigative is determined at the sole discretion of the Network Administrator.

Experimental/Investigative is the use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which is not determined by the Network Administrator to be medically effective for the condition being treated.

The Network Administrator will consider an intervention to be Experimental/Investigative if: the intervention does not have FDA approval to be marketed for the specific relevant indication(s); or available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or the intervention is not proven to be as safe or as effective in achieving an outcome equal to or exceeding the outcome of the alternative therapies; or the intervention does not improve health outcomes; or the intervention is not proven to be applicable outside the research setting. If an intervention, as defined above, is determined to be experimental/investigative at the time of the service, it will not receive retroactive coverage, even if it is found to be in accordance with the above criteria at a later date.

Full-Time Employee

An employee who is regularly scheduled to work more than 32 hours per week for an Employer.

Furlough

When a temporary working schedule, less than the employee's normal schedule, is in effect.

Hourly Employee

An employee who is classified as hourly on the Employer's payroll system.

Involuntary and Voluntary Separation

Involuntary Separation means separation by Layoff, Permanent Job Separation, release, or discharge through no fault of your own for reasons related to the business. All other separations are considered voluntary, including quitting, resigning, retiring, failing to report for work when not excused, and failing to return to work when recalled from an inactive seniority roll.

Job-Related

Sickness or injury for which you are entitled to benefits under workers' compensation or occupational disease laws or similar laws. It does not mean sickness or injury that you incur as an employee of any other employer.

Layoff

Your employment ends through no fault of your own for lack of work for reasons related to the business, and the Employer determines there is a reasonable expectation of recall within one year.

Leave of Absence

A continuous period of 30 days or more away from work where the intent is to reinstate the employee at the expiration of the leave. The Employer must approve a Leave of Absence before the Leave of Absence begins.

Lifetime Maximum

The aggregate total amount of benefits payable for all expenses incurred on account of all injuries and sicknesses to any individual under medical coverage received from an out-of-network provider. There are separate Lifetime Maximums for orthodontic expenses under dental coverage and for the hospital program for you and your spouse combined under Special Programs with Medicare (SPM).

Maintenance Drug; Maintenance Medication

A medication prescribed for the treatment of a chronic condition (such as high blood pressure or diabetes) and which you or a covered dependent will continue to take for 30 days or more.

Medically Necessary and Appropriate

Medically Necessary and Appropriate services or supplies are those provided by an approved facility or provider that the Network Administrator determines:

- are appropriate for the symptoms and diagnosis or treatment of your condition, illness, disease or injury;
- are provided for the diagnosis, or the direct care and treatment of your condition, illness, disease or injury;
- are in accordance with standards of good medical practice;
- are not primarily for your convenience, or the provider's; and
- are the most appropriate supply or level of service that can safely be provided to you.

When applied to hospitalization, this further means that you require acute care as an inpatient due to the nature of the services rendered or your condition, and you cannot receive safe or adequate care as an outpatient. The Network Administrator reserves the right to determine, in its sole judgment, whether a service is Medically Necessary and Appropriate. No benefits will be provided unless the Network Administrator determines that the service or supply is Medically Necessary and Appropriate.

Network Administrator

The organization that credentials, evaluates, and contracts with providers to establish a network of providers; pays claims according to Plan provisions; and makes determinations regarding Covered Expenses, including determinations as to whether charges are Usual, Customary and Reasonable and whether services or products are Experimental/Investigative or Medically Necessary and Appropriate.

No Coverage

Your decision not to be covered for a given benefit offered through the Plan.

Out-of-Pocket Maximum

The highest amount you are required to pay in Co-payments and Deductibles for any Covered Expenses that you or your covered dependents have in a calendar year. When you or your covered dependents reach the Out-of-Pocket Maximum for the calendar year, the coverage pays 100% of the Allowable Amount for all remaining Covered Expenses for the rest of the calendar year, up to the Lifetime Maximum except for the $15 office visit Co-payment and the $25 emergency room Co-payment and your Co-payments under mental health and substance abuse treatment, prescription drug and vision coverage. The Out-of-Pocket Maximum refers to Allowable Expenses only. If you do not use preferred or participating providers, you may incur charges above the Allowable Amount. You are responsible for any such charges, and these expenses do not count toward your Out-of-Pocket Maximum.

The $15 in-network office visit Co-payment, the $25 emergency room visit Co-payment, and any out-of-pocket expenses that you pay for mental health and substance abuse treatment, prescription drug, or vision coverage do not apply toward the annual Out-of-Pocket Maximum.

Part-Time Employee

An employee who is regularly scheduled to work between 24 and 32 hours per week for an Employer.

Permanent Job Separation; Permanent Separation

When your employment ends through no fault of your own for lack of work for reasons related to the business and Westinghouse has no reasonable expectation of re-employment. You are not considered to be permanently separated if you are offered continued employment by:

- The Employer;
- A subsidiary of the Employer;
- A Successor Employer;
- Any employer at least 50% owned by an Employer; or
- Any employer partly owned by an Employer that participates in the Westinghouse Government Services Group Pension Plan, the West Valley Pension Plan, or the Tru Solutions Pension Plan.

Plan

The Westinghouse Government Services Group Welfare Benefits Plan.

Plan Year

The 12-month period for which current benefits, limits, Deductibles, and maximums apply. For the Westinghouse Government Services Group Welfare Benefits Plan, the Plan Year is the calendar year (January 1 -December 31).

Post-Service Claim

Any claim for a benefit for medical care or treatment that is not a Pre-Service Claim or an Urgent Health Care Claim.

Pre-Service Claim

Any claim for a benefit where approval of the claim is required prior to obtaining medical care.

Pre-Tax Contribution

Employee contributions on which no federal or state income tax or Social Security tax is paid when they are used to purchase a benefit coverage under the Plan or placed in a Spending Account.

Preventive Care

Any medical or dental service that is designed to avoid illness or promote wellness.

Qualified Medical Child Support Order (QMCSO)

Any court order which:

1. Provides for child support with respect to a participant's child or directs the participant to provide coverage under a health benefits plan under a state domestic relations law, or
2. Enforces a law relating to medical child support described in Social Security Act, Section 1908, with respect to a group health plan.

Retire

Retire as used in this Plan means retirement directly following active employment at age 58 with 30 years of Eligibility Service, age 60 with 10 years of Eligibility Service, or age 65 with 5 years of Eligibility Service.

Salaried Employee

An employee who is classified as salaried on the payroll system.

Spending Account

An account that permits you to receive non-taxable benefits for IRS-approved health care expenses or day care costs. When you enroll in a Spending Account, you authorize the Employer to make Pre-Tax Contributions to these accounts on your behalf.

Spending Account Administrator

The company, currently FlexBen Corporation, designated by the Plan Administrator to fulfill the Spending Account administrative functions of the Plan.

Successor Employer

An employer that buys or takes control of the Employer's business, as determined by Westinghouse Government Services Group, and that employs you.

Total Disability; Totally Disabled

The inability, because of an illness or injury, to engage in any gainful occupation for which you are reasonably qualified by education, training, experience, and past earnings as determined by the insurance company or Total Disability Manager. However, for the first 12 months of your absence due to disability, you will be considered Totally Disabled if you are unable, because of illness or injury, to perform each of the material duties of your occupation as determined by the insurance company or Total Disability Manager. In addition, you must be under the care of a physician for any required treatment of your disability and, when the insurance company or Total Disability Manager requests it, you must provide satisfactory proof of your continued Total Disability.

Total Disability Manager; Total Disability Management Administrator

The company, currently Hartford Life and Accident Company, designated by the Plan Administrator to fulfill the disability case management functions of the Plan.

Total and Permanent; Total and Permanent Disability; Totally and Permanently Disabled

A disability is considered Total and Permanent if you are wholly prevented from performing any work. The insurance carrier or Total Disability Manager must approve you for Total and Permanent Disability benefits.

Urgent Health Care Claim

A claim for medical care or treatment where the time periods for making non-urgent care determinations could (i) seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or (ii) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Usual, Customary, and Reasonable (UCR) Charges

The fees set by the Network Administrator that reflect typical fees charged for services in your area. This means that the charge for a claim is usual for that particular service, that the fee is customary for a particular area, and that it is reasonable based on the particular medical circumstances. Network Administrators assign UCR levels to all medical and dental services and pay claims based on those levels. Expenses above these amounts are not paid or covered under the terms of the benefit coverages. The Network Administrator may refer to these charges as “Allowable Amounts” or “Allowable Expenses” on claims statements.

Waiting Period

The period before all health and welfare benefits begin. The Waiting Period for all coverages, except Business Travel Accident Insurance Coverage, is until the 1st of the month following 30 days of continuous employment. Business Travel Accident Insurance Coverage starts on the 1st day of employment with an Employer.

Westinghouse

Westinghouse Government Services Group and any successor entity.

Westinghouse Benefits Center; Benefits Center

The service center, currently managed by Hewitt Associates, designated by the Plan Administrator to fulfill the administrative functions of the Plan, such as, among other tasks, processing Plan enrollment.

Appendix C – Medical Coverage

Details of the Premium and Standard PPO Medical Coverage Options

Benefits	Premium PPO Medical Coverage		Standard PPO Medical Coverage	
	In-Network Care	**Out-of-Network Care**	**In-Network Care**	**Out-of-Network Care**
Deductible • Individual • Family	 $150 $250	 $350 $650	 $350 $650	 $950 $1850
Medical Option Pays	90% after Deductible	70% after Deductible	80% after Deductible	60% after Deductible
Employee Co-Payment (Except office/ER visits as noted below)	10%	30%	20%	40%
Physician Office Visits	100% after $15 Co-payment/visit*	70% after Deductible	100% after $15 Co-payment/visit*	60% after Deductible
Out-of-Pocket Maximum (excludes Co-payments for physician office/ER visits and amounts over UCR)	$1,500 Individual $2,500 Family	$3,500 Individual $6,500 Family	$2,500 Individual $4,500 Family	$4,500 Individual $8,500 Family
Lifetime Maximum	Unlimited	$300,000	Unlimited	$300,000
Preventive Care - Adult • Routine physical exams	100% after $15 Co-payment/visit*	Not Covered	100% after $15 Co-payment/visit*	Not Covered
• Routine gynecological exams, including a PAP Test	100% after $15 Co-payment/visit*	70% after Deductible	100% after $15 Co-payment/visit*	60% after Deductible
• Mammograms, as required	100%; No Deductible	70% after Deductible	100%; No Deductible	60% after Deductible

Notes:

- The office visit Co-payments apply to the charge for the visit only. If any other eligible services are performed during the visit, such as lab work or x-rays, those services would be subject to the Deductible and Co-payment. For example, a routine gynecological exam and pap test are not subject to coverage Deductibles and maximums. However, the laboratory analysis of the pap smear itself is subject to coverage Deductible and maximums.
- Preventive Care is covered according to the carrier's schedule. If a test performed during a routine physical exam is not on the carrier's schedule for Preventive Care, it will not be covered unless there was a diagnostic reason for performing the test.

Benefits	Premium PPO Medical Coverage		Standard PPO Medical Coverage	
	In-Network Care	**Out-of-Network Care**	**In-Network Care**	**Out-of-Network Care**
Preventive Care - Pediatric • Routine physical exams	100% after $15 Co-payment/visit*	Not Covered	100% after $15 Co-payment/visit*	Not Covered
• Pediatric immunizations	100%; No Deductible	70% after Deductible	100%; No Deductible	60% after Deductible
Notes: • The office visit Co-payments apply to the charge for the visit only. If any other eligible services are performed during the visit, such as lab work or x-rays, those services would be subject to the Deductible and Co-payment. • Childhood immunizations are not subject to coverage Deductibles and maximums. However, any separate charges for administration of the immunization are subject to coverage Deductible and maximums. • Preventive Care is covered according to the carrier's schedule. If a test performed during a routine physical exam is not on the carrier's schedule for Preventive Care, it will not be covered unless there was a diagnostic reason for performing the test.				
Emergency Room Visits	100% after $25 Co-payment/visit* (waived if admitted)		100% after $25 Co-payment/visit* (waived if admitted)	
Maternity	90% after Deductible	70% after Deductible	80% after Deductible	60% after Deductible
Infertility Counseling, testing and treatment **	90% after Deductible	70% after Deductible	80% after Deductible	60% after Deductible
Assisted fertilization procedures	Not Covered	Not Covered	Not Covered	Not Covered
Hospital expenses (inpatient and outpatient)	90% after Deductible	70% after Deductible	80% after Deductible	60% after Deductible
Medical/Surgical Expenses (Except office visits)	90% after Deductible	70% after Deductible	80% after Deductible	60% after Deductible
Diagnostic Services (Lab, X-Ray, and other tests)	90% after Deductible	70% after Deductible	80% after Deductible	60% after Deductible
Physical Therapy (Professional)	90% after Deductible	70% after Deductible	80% after Deductible	60% after Deductible
Spinal Manipulations Limit: 25 visits/calendar year, combined in and out of network	90% after Deductible	70% after Deductible	80% after Deductible	60% after Deductible

Benefits	Premium PPO Medical Coverage		Standard PPO Medical Coverage	
	In-Network Care	**Out-of-Network Care**	**In-Network Care**	**Out-of-Network Care**
Durable Medical Equipment	90% after in-network Deductible		80% after in-network Deductible	
Hearing Aids • $400 limited to 2 in 3 consecutive calendar years	90% after Deductible	70% after Deductible	80% after Deductible	60% after Deductible
Ambulance	90% after in-network Deductible		80% after in-network Deductible	
Skilled Nursing Facility Care • Limit: 30 days/calendar year	90% after in-network Deductible		80% after in-network Deductible	
Home Health Care • Limit: 30 visits/calendar year	90% after in-network Deductible		80% after in-network Deductible	
Hospice	90% after in-network Deductible		80% after in-network Deductible	
Private Duty Nursing • Limit: $20,000/calendar year	90% after in-network Deductible		80% after in-network Deductible	
Speech, Occupational Therapy (Professional)	90% after in-network Deductible		80% after in-network Deductible	
Precertification Requirements	Performed by Employee[1]		Performed by Employee[1]	

The percentages specified are the percentages of the Network Administrator's Allowance.

* The $15 office visit and $25 emergency room visit Co-payments do not apply to the Deductible or the Out-of-Pocket Maximum. The office visit and emergency room visit Co-payments apply to the charge for the visit only. If any other eligible services are performed during the visit, such as lab work or x-rays, those services would be subject to the Deductible and Co-payment.

** Treatment includes coverage for the correction of a physical or medical problem associated with infertility.

[1] If Highmark Blue Cross Blue Shield is not contacted 7-14 days prior to an inpatient admission and it is later determined that all or part of the inpatient stay was not Medically Necessary or Appropriate, the patient will be responsible for payment of any costs not covered. If you or any of your covered dependents are admitted to a hospital as a result of an emergency, you are responsible for notifying Highmark Blue Cross Blue Shield within 48 hours after the admission. Under each of the options, please note that **you** are responsible for pre-certifying any in-hospital stays or penalties may apply. Precertification applies only for inpatient admissions (including surgical admission). You can ask the provider to obtain the precertification; however, it is ultimately your responsibility to make sure the call is made. Outpatient surgery does not require precertification since it does not involve an inpatient admission.

Details of the Mental Health and Substance Abuse Treatment Coverage

	Premium PPO		**Standard PPO**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Mental Health and Substance Abuse Treatment (through ValueOptions)	90% if certified Inpatient: 30 days Outpatient: 60 visits	60% if certified 30 days 30 visits	80% if certified Inpatient: 30 days Outpatient: 60 visits	50% if certified 30 days 30 visits
	Inpatient non-certified care: 40% (15 days) Outpatient non-certified care: 25% (15 visits)			

- The percentages specified are the percentages of the Network Administrator's Allowance.
- The number of days or visits specified are Plan Year maximums.
- Benefits for alcohol or drug rehabilitation treatment, including detoxification, are limited to two Medically Necessary and Appropriate episodes of care per lifetime, inpatient or outpatient, for each covered person.

Details of Prescription Drug Coverage

	In-Network	Out-of-Network
Retail Pharmacies	• Prescription drug coverage will be provided in three tiers: 1. Generic prescription drugs – participants will pay 20% of the cost of in-network generic drugs; 2. Brand-name formulary ("preferred") prescription drugs – participants will pay 30% of the cost of in-network brand-name formulary (preferred) prescription drugs; and 3. Brand-name non-formulary ("non-preferred") prescription drugs - participants will pay 35% of the cost of in-network brand-name non-formulary (non-preferred) prescription drugs plus $15 for each fill of a prescription. Covered prescription drugs are dispensed according to the above 3-tier structure with no exceptions. • Limited to a 30-day supply • No claim forms are required	• You pay the full cost of the covered prescription at the time of purchase • Submit a claim to the Network Administrator • The Plan reimburses you 20% of the cost of the covered prescription
Mail-Service Pharmacy	• Prescription drug coverage will be provided in three tiers: 1. Generic prescription drugs – participants will pay 20% of the cost of in-network generic drugs; 2. Brand-name formulary ("preferred") prescription drugs – participants will pay 30% of the cost of in-network brand-name formulary (preferred) prescription drugs; and 3. Brand-name non-formulary ("non-preferred") prescription drugs - participants will pay 35% of the cost of in-network brand-name non-formulary (non-preferred) prescription drugs plus $15 for each fill of a prescription. Covered prescription drugs are dispensed according to the above 3-tier structure with no exceptions. • Limited to a 90-day supply (except controlled substances as restricted by law)	Not Applicable

- You may purchase your covered prescription drugs through the network in one of two ways. You may purchase up to a 30-day supply at a network retail pharmacy, or up to a 90-day supply through the mail service pharmacy. The mail service pharmacy is mandatory for maintenance medications, but can also be used for non-maintenance medications as well. You may purchase the initial fill of a Maintenance Medication, plus a 30-day refill, at a network retail pharmacy without penalty, but all subsequent refills of this medication must be filled through the mail service in order to obtain the

higher benefit level. In fact, it may be beneficial to have your first Maintenance Medication prescription filled at a network retail pharmacy in case you have an adverse reaction to the medication. This way, you will have only paid your Co-payment on a 30-day supply rather than a 90-day supply if you need to switch medications. To take advantage of this provision, when your physician first prescribes a new Maintenance Medication for you, ask your physician to write two prescriptions – one for a 30-day supply plus one 30-day refill, and one for a 90-day supply with up to 3 additional refills (except where restricted by law). Have the 30-day supply filled at a network retail pharmacy. Once you are comfortable that you do not experience any adverse side effects from the Maintenance Medication, have the 90-day supply filled at the mail service pharmacy. This way, you maximize your benefits and are not paying for a large supply of medication that you may not be able to use.

- If you choose to obtain refills at an in-network retail pharmacy for subsequent Maintenance Medications that should be filled through the mail service pharmacy, you must pay the difference between the mail service price and the retail price, plus your applicable Co-payment on the mail order price.

- Generic medication will be supplied unless the physician prescribing the medication indicates "dispense as written (DAW)". If a covered generic medication is available in place of the brand name drug, and you elect to purchase the brand rather than the generic drug, even if your physician indicated "dispense as written (DAW)", you will pay the difference between the brand price and the generic price, plus the applicable Co-payment on the generic price. This is applicable to both in-network retail pharmacies and the mail service pharmacy. **There are no exceptions to this, even if a person cannot take a generic for medical reasons.**

- Non-covered fertility drug prescriptions can be purchased at a network pharmacy or through the mail service pharmacy at 100% Co-payment. If you purchase these non-covered prescriptions at a network pharmacy or through the mail service pharmacy, you will receive the network discount price.

- If you pay $2,500 for covered prescription drug expenses out of your own pocket for a covered person, the Plan covers all remaining eligible prescription drug expenses for that person for the remainder of the Plan Year at 100%.

Details of Prescription Drug Coverage under Special Programs with Medicare (SPM)

	In-Network	Out-of-Network
Retail Pharmacies	• You pay 50% of the cost of a covered prescription at the time of purchase; the Plan pays 50% • Limited to a 30-day supply • No claim forms are required	• You pay the full cost of the covered prescription at the time of purchase • Submit a claim to the Network Administrator • The Plan reimburses you 20% of the cost of the covered prescription
Mail-Service Pharmacy	• You pay 50% of the cost of a covered prescription, by personal check or major credit card; the Plan pays 50% • Limited to a 90-day supply (except controlled substances as restricted by law)	

- You may purchase your covered prescription drugs through the network in one of two ways. You may purchase up to a 30-day supply at a network retail pharmacy, or up to a 90-day supply through the mail service pharmacy. The mail service pharmacy is mandatory for maintenance medications, but can also be used for non-maintenance medications as well. You may purchase the initial fill of a Maintenance Medication, plus a 30-day refill, at a network retail pharmacy without penalty, but all subsequent refills of this medication must be filled through the mail service in order to obtain the higher benefit level. In fact, it may be beneficial to have your first Maintenance Medication prescription filled at a network retail pharmacy in case you have an adverse reaction to the medication. This way, you will have only paid your Co-payment on a 30-day supply rather than a 90-day supply if you need to switch medications. To take advantage of this provision, when your physician first prescribes a new Maintenance Medication for you, ask your physician to write two prescriptions – one for a 30-day supply plus one 30-day refill, and one for a 90-day supply with up to 3 additional refills (except where restricted by law). Have the 30-day supply filled at a network retail pharmacy. Once you are comfortable that you do not experience any adverse side effects from the Maintenance Medication, have the 90-day supply filled at the mail service pharmacy. This way, you maximize your benefits and are not paying for a large supply of medication that you may not be able to use.

- If you choose to obtain refills at an in-network retail pharmacy for subsequent Maintenance Medications that should be filled through the mail service pharmacy, you must pay the difference between the mail service price and the retail price, plus your 50% Co-payment on the mail order price.

- Generic medication will be supplied unless the physician prescribing the medication indicates "dispense as written (DAW)". If a covered generic medication is available in place of the brand name drug, and you elect to purchase the brand rather than the generic drug, even if your physician indicated "dispense as written (DAW)", you will pay the difference between the brand price and the generic price, plus the 50% Co-payment on the generic price. This is applicable to both in-network retail pharmacies and the mail service pharmacy. **There are no exceptions to this, even if a person cannot take a generic for medical reasons.**

- Non-covered fertility drug prescriptions can be purchased at a network pharmacy or through the mail service pharmacy at 100% Co-payment. If you purchase these non-covered prescriptions at a network pharmacy or through the mail service pharmacy, you will receive the network discount price.

Details of Vision Coverage — Schedule of Maximum Benefits

Service	In-Network (VSP)	Out-of-Network
Vision Exam	100% after $15 Co-payment	$35.00
Lens (per set)		
• Single Vision	$50	$50
• Bifocal	$70	$70
• Trifocal	$95	$95
• Lenticular (Biconvex)	$105	$105
• Contact	$90	$90
Frames	$50	$50

Your vision care benefits cover vision exams once in every other calendar year. They replace lenses and/or frames, or contact lenses instead of lenses and/or frames, once every other calendar year.

Appendix D – Dental Coverage

Details of the Dental Options

PREMIUM DENTAL PPO		
Coverage Feature	**In-Network**	**Out-of-Network**
Annual Deductible	None	
Annual Maximum	$1,000 per covered person	
Lifetime Orthodontia Maximum	$1,000 per covered person	
Preventive Services		
Routine Exams • Exams: 2 per calendar year • Full Mouth x-rays: 1 every 36 months • Bitewings: 2 per calendar year	100%	90%
Teeth Cleaning • Maximum of 2 per year	100%	90%
Fluoride Treatments (up to 19th birthday) • Maximum of 2 per year	100%	90%
Sealants - Permanent Molars only (up to 15th birthday) • 2 treatments per tooth	100%	90%
Space Maintainers (up to 19th birthday)	100%	90%
Basic Services		
Endodontics (root canals)	80%	70%
Periodontics	80%	70%
Oral Surgery	80%	70%
Simple Extractions	80%	70%
General Anesthesia – when Medically Necessary and Appropriate	80%	70%
Routine Fillings	80%	70%
Crown, Denture, & Bridge Repair	80%	70%
Major Services		
Inlays, Onlays, & Crowns	50%	40%

PREMIUM DENTAL PPO		
Coverage Feature	**In-Network**	**Out-of-Network**
Bridges & Dentures • 1 per 60 months	50%	40%
Orthodontia		
Braces (includes all related care, supplies and service) • Orthodontia treatment must begin before the eligible dependent's 19th birthday • $1,000 lifetime per covered Eligible Dependent	50%	50%

The percentages specified above are the percentages of the maximum allowable charge.

STANDARD DENTAL PPO		
Coverage Feature	**In-Network**	**Out-of-Network**
Annual Deductible	None	
Annual Maximum	$1,000 per covered person	
Lifetime Orthodontia Maximum	$1,000 per covered person	
Preventive Services		
Routine Exams • Exams: 2 per calendar year • Full Mouth x-rays: 1 every 36 months • Bitewings: 2 per calendar year	80%	60%
Teeth Cleaning • Maximum of 2 per year	80%	60%
Fluoride Treatments (up to 19th birthday) • Maximum of 2 per year	80%	60%
Sealants - Permanent Molars only (up to 15th birthday) • 2 treatments per tooth	80%	60%
Space Maintainers (up to 19th birthday)	80%	60%
Basic Services		
Endodontics (root canals)	60%	40%
Periodontics	60%	40%

STANDARD DENTAL PPO		
Coverage Feature	**In-Network**	**Out-of-Network**
Oral Surgery	60%	40%
Simple Extractions	60%	40%
General Anesthesia – when Medically Necessary and Appropriate	60%	40%
Routine Fillings	60%	40%
Crown, Denture, & Bridge Repair	60%	40%
Major Services		
Inlays, Onlays, & Crowns	50%	30%
Bridges & Dentures • 1 per 60 months	50%	30%
Orthodontia		
Braces (includes all related care, supplies and service) • Orthodontia treatment must begin before the eligible dependent's 19th birthday • $1,000 lifetime per covered Eligible Dependent	50%	50%

The percentages specified above are the percentages of the maximum allowable charge.

Appendix E – What Is Not Covered Under Medical Coverage

The Premium PPO, Standard PPO and the Comprehensive Out-Of-Area medical coverage options cover the same services. None of the Plan's medical coverage options will provide benefits for services, supplies or charges:

- Which are not Medically Necessary and Appropriate as determined by the Network Administrator
- Which are not prescribed by or performed by or upon the direction of a professional provider
- Which are in excess of the Usual, Customary and Reasonable Charges or the Allowance
- Which are provided by other than hospitals, physicians, other facility providers, professional providers or suppliers who are certified and approved for payment by the Network Administrator
- Which are Experimental / Investigative in nature as determined by the Network Administrator
- Which are rendered prior to your benefit eligibility date
- Which are incurred after the termination date of your coverage, except as provided by the Plan
- For any illness or injury suffered after your effective date as a result of any act of war
- For which you would have no legal obligation to pay
- Which are received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group
- To the extent payment has been made under Medicare when Medicare is primary or would have been made if you had applied for Medicare, claimed Medicare benefits and Medicare was primary; however, this exclusion shall not apply when the group is obligated by law to offer you the benefits of this program and you elect this coverage as primary or the law provides that this coverage is primary
- For any amounts you are required to pay under the Deductible and/or Co-payment provisions of Medicare or any Medicare supplement coverage
- For any illness or injury which occurs in the course of employment if benefit or compensation are available, in whole or in part, under the provisions of any federal, state or local government's workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation
- To the extent benefits are provided to members of the armed forces and the National Health Service or to patients in Veterans' Administration facilities for service-connected illness or injury unless you have a legal obligation to pay
- For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor

vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsbility Act

- For prescription drugs and medicines requiring a legally licensed physician's prescription and dispensed by a legally licensed pharmacist, except those which are administered to an inpatient in a facility provider, and except as provided by the prescription drug coverage under the Plan
- For nicotine cessation support programs and/or classes
- For any treatment, whether in-patient or out-patient, for mental health and substance abuse treatment, except as provided by the mental health and substance abuse treatment coverage under the Plan
- For methadone hydrochloride treatment for which no additional functional progress is expected to occur
- Which are submitted by a certified registered nurse and another professional provider for the same services performed on the same date for the same patient
- Rendered by a provider who is a member of the patient's immediate family or who resides in the same household as the patient
- Which are performed by a professional provider enrolled in an education or training program when such services are related to the education or training program
- For ambulance services, except as provided by the Plan
- For operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except as otherwise required by law. Other exceptions to this exclusion are: a) surgery to correct a condition resulting from an accident; b) surgery to correct congenital birth defects; and c) surgery to correct a functional impairment which results from a covered disease or injury
- For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form
- For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, physical fitness equipment, stair glides, elevators/ lifts or “barrier free” home modifications, whether or not specifically recommended by a professional provider
- For inpatient admissions which are primarily for diagnostic studies
- For inpatient admissions primarily for physical therapy
- For custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care
- For therapy services for which no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, and which are determined not to be Medically Necessary and Appropriate
- For respite care

- Which are directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except for certain orthodontic treatment for congenital cleft palates as provided in conjunction with maxillary alveolar bone graft surgery, and the congenital cleft is a complete cleft of the maxillary alveolus. Treatment is limited to pre-surgical orthodontics to align the alveolar segments of the maxillary arch prior to bone graft surgery and orthodontic stabilization following bone graft surgery to hold the maxillary alveolar segments in position until the bone grafts have stabilized

- For oral surgery procedures, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face, and the removal of partially or fully boney impacted wisdom teeth, unless specifically provided

- For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma

- For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes

- For tinnitus maskers, or examinations for the prescription or fitting of hearing aids

- For any treatment leading to or in connection with transsexual surgery; except for sickness or injury resulting from such surgery

- For treatment provided specifically for the purpose of assisted fertilization, including pharmacological or hormonal treatments used in conjunction with assisted fertilization, unless mandated or required by law

- For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses / glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury) except as provided by the vision coverage under the Plan

- For correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants and LASIX

- For nutritional counseling and services except as provided by the Plan

- For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless Medically Necessary and Appropriate

- For Preventive Care services, wellness services or programs, except as provided by the Plan or as mandated by law

- For well baby care and immunizations, except as provided by the Plan

- For allergy testing, except as provided by the Plan or as mandated by law

- For routine or periodic physical examinations, the completion of forms, and preparation of specialized reports solely for insurance, licensing, employment or other on-preventive purpose, suchas pre-marital examinations, physicals for school, camp, sports or travel, which are not Medically Necessary and Appropriate, except as provided by the Plan or as mandated by law
- For immunization required for foreign travel or employment
- For any treatment of sexual dysfunction not related to organic disease or injury
- For any condition related to autistic disease of childhood, learning disabilities, and mental retardation which extends beyond traditional medical management or for inpatient confinement for environmental change
- For any care, treatment or service which has been disallowed under the precertification provisions of the Plan
- For treatment or services for which you are paid because of legal action or settlement
- For dietary or food supplements
- For Covered Services that exceed any calendar year limits or the Lifetime Maximum
- For any other medical or dental service or treatment, except as provided by the Plan or as mandated by law

In addition, under the prescription drug coverage, the following are also excluded:

- Any prescription for more than a 30-day supply of drugs, unless purchased through the mail service pharmacy
- Any prescription for more than a 90-day supply of drugs when purchased through the mail service pharmacy
- Any charge for administration of drugs or insulin
- Any drug or medication, except as provided by the Plan
- Any amounts you are required to pay directly to the pharmacy for each prescription or refill
- Charges for a prescription drug when such drug or medication is used for unlabeled or unapproved indications where such use has not been approved by the FDA
- Any charge for a contraceptive medication other than oral contraceptives when such medication is used for contraceptive purposes and not for purposes in which the medication is Medically Necessary and Appropriate
- Any charges for therapeutic devices or appliances, except as provided by the Plan
- Any drug that is not on the list of covered drugs maintained by the Network Administrator.

In addition, under the mental health and substance abuse treatment coverage, the following are also excluded:

- Art therapy
- Marathon therapy
- Bioenergetic therapy
- Megavitamin or orthomolecular therapy
- Carbon dioxide therapy
- Narcotherapy with LSD
- Confrontation therapy
- Outward Bound programs
- Consultation with a mental health professional for purposes of adjudication of marital & child support / custody cases
- Primal therapy
- Poetry therapy
- Rechecked chart review
- Rolfing
- Sedative action electrostimulation therapy
- Sensitivity training
- Educational remediation
- Sex addiction
- Est (Erhard) & its derivatives
- Sex therapy (without the DSM-IV diagnosis)
- Gambling programs based solely on the 12 step (AA/NA model)
- Training analysis (tuitional, orthodox)
- Transcendental meditation
- Guided imagery
- Wilderness camps (including boot camps)
- Hemodialysis for schizophrenia

- Z therapy
- L-Tryptophan & vitamins, except thiamin injections (X-13) on admission for alcoholism & logical treatments
- Hyperbaric or nomobaric oxygen therapy

In addition, under the vision coverage, the following are also excluded:

- Sunglasses
- Additional charges for photosensitive or anti-reflective lenses
- Any vision care service you received or ordered before the Plan covered you or after your coverage stops
- Any excess charges over the scheduled vision care benefits
- Orthoptics or vision training and any associated supplemental testing
- Plano lenses
- Medical or surgical treatment of the eyes
- Replacement of lenses and frames furnished under this coverage, except as provided under the Plan

In addition, under the Special Programs with Medicare's (SPM) Hospital Program, the following are also excluded:

- Any expenses beyond the $600 in-hospital benefit per Benefit Period while in the United States
- Any expenses above the $60,000 combined Lifetime Maximum for you and your spouse

Appendix F – What Is Not Covered Under Dental Coverage

The Premium and Standard dental coverage PPO options cover the same services. Neither dental coverage option will provide benefits for:

- Services or supplies incurred prior to your benefit eligibility date or after your benefit termination date
- Services not performed by a licensed dentist, except for scaling and polishing of teeth or fluoride treatments performed by a licensed dental hygienist under the supervision and billing of a licensed dentist
- Services or supplies which are not necessary in terms of generally accepted dental standards, as determined by the Network Administrator
- Cosmetic surgery, treatment or supplies, unless required for the treatment or correction of a congenital defect of a newborn child who is an eligible dependent
- Replacement of a lost, missing or stolen crown, bridge or denture
- Services or supplies which are covered by any workers compensation laws or occupational disease laws
- Services or supplies which are covered by any employers' liability laws
- Services or supplies which any employer is required by law to furnish in whole or in part
- Services or supplies received through a medical department or similar facility which is maintained by the Employer
- Repair or replacement of an orthodontic appliance
- Services or supplies received for which no charge would have been made in the absence of dental benefits
- Services or supplies that an employee is not required to pay
- Provider’s charges in excess of the Allowance as set by the Network Administrator
- Services or supplies which are deemed experimental in terms of generally accepted dental standards, as determined by the Network Administrator
- Services or supplies received as a result of dental disease, defect, or injury due to an act of war, or a warlike act in time of peace, which occurs while dental benefits are in effect
- Adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it
- Any duplicate appliance or prosthetic device
- Use of material or home health aids to prevent decay, such as toothpaste or fluoride gels, with the exception of the topical application of fluoride twice a year for dependents up to their 19th birthday

- Instruction for oral care such as hygiene or diet
- Periodontal splinting
- Services or supplies to the extent that benefits are otherwise provided under this Plan or under any other plan which Westinghouse contributes to or sponsors
- Implantology
- Initial installation of a denture or bridgework to replace one or more natural teeth lost before your dental benefits started
- Charges for broken appointments
- Charges by the dentist for completing dental forms
- Sterilization supplies
- Services or supplies furnished by a family member
- Treatment of temporomandibular joint disorders
- Appliances or treatment for bruxism (grinding teeth) including but not limited to occlusal guards and night guards
- Covered Services that exceed any calendar year limits or Lifetime Maximum under the Plan
- Treatment or services for which you are paid because of legal action or settlement
- Any other dental service or treatment, except as provided by the Plan

Appendix G – MetLife Life Insurance Booklets

- **Life and Accidental Death and Dismemberment (AD&D) Insurance and Dependent Life Insurance**
- **Basic Life and Accidental Death and Dismemberment (AD&D) for Part-Time Employees**
- **Personal Accident Insurance Coverage**
- **Additional / Supplemental Life Insurance Coverage – Grandfathered as of 12/31/91**

YOUR EMPLOYEE BENEFIT PLAN

WESTINGHOUSE GOVERNMENT SERVICES GROUP

Life and Accidental Death and Dismemberment (AD&D) Insurance

Dependent Life Insurance

NOTICE TO INSUREDS

READ THIS NOTE CAREFULLY

Westinghouse Government Services Group maintains the group insurance policy, including a copy of the certificate of insurance that is available for you to review and copy if necessary. If there is any conflict between the information in this copy and the group insurance policy and certificate, the policy and certificate shall control in all respects.

Westinghouse Government Services Group
4350 Northern Pike; Room 217C
Monroeville, PA 15146

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

This certificate describes the benefits that are available to you. We urge you to read it carefully.

Benefits are provided through a group policy issued to Westinghouse Government Services Group by Metropolitan Life Insurance Company.

Westinghouse Government Services Group

MetLife®

Metropolitan Life Insurance Company
One Madison Avenue, New York, New York 10010-3690

Certifies that, under and subject to the terms and conditions of the Group Policy issued to the Employer, coverage is provided for each Employee as defined herein.

The date when an Employee is eligible for coverage is set forth in the form with the title Eligibility for Benefits.

The date when an Employee's Personal Benefits become effective is set forth in the form with the title Effective Dates of Personal Benefits.

The date when an Employee's Dependent Benefits become effective is set forth in the form with the title Effective Dates of Dependent Benefits.

The amounts of coverage are determined by the form with the title Schedule of Benefits.

Robert H. Benmosche
Chairman, President and Chief Executive Officer

Employer: **Westinghouse Government Services Company, LLC, and Westinghouse Government Environmental Services Company, LLC**

Group Policy No.: **96934-G**

Florida Residents: The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida.

For Maryland residents: The group insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

If any prior certificate relating to the coverage set forth herein has been given to the Employee, such certificate is void.

Form G.23000-Cert.-1

For Texas Residents:

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call MetLife's toll-free telephone number for information or to make a complaint at

1-800-638-5433

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
Fax # 512 - 475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact MetLife first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR CERTIFICATE: This notice is for information only and does not become a part or condition of the attached document.

Para Residentes de Texas:

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de MetLife para informacion o para someter una queja al

1-800-638-5433

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas
P.O. Box 149104
Austin, TX 78714-9104
Fax # 512 - 475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con MetLife primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU CERTIFICADO: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

Arkansas residents please be advised of the following:

IMPORTANT NOTICE

IF YOU HAVE A QUESTION CONCERNING YOUR COVERAGE OR A CLAIM, FIRST CONTACT YOUR GROUP EMPLOYER OR GROUP ACCOUNT ADMINISTRATOR. IF, AFTER DOING SO, YOU STILL HAVE A CONCERN, YOU MAY CALL METLIFE'S TOLL-FREE TELEPHONE NUMBER:

1-800-638-5433

IF YOU ARE STILL CONCERNED AFTER CONTACTING BOTH YOUR GROUP EMPLOYER AND METLIFE, YOU SHOULD FEEL FREE TO CONTACT:

ARKANSAS INSURANCE DEPARTMENT
CONSUMER SERVICES DIVISION
1200 WEST THIRD
LITTLE ROCK, ARKANSAS 72201-1904

California residents please be advised of the following:

IMPORTANT NOTICE

TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT METLIFE AT:

METROPOLITAN LIFE INSURANCE COMPANY
1 MADISON AVENUE
NEW YORK, NY 10010
ATTN: CORPORATE CONSUMER RELATIONS DEPARTMENT
1-800-638-5433

IF, AFTER CONTACTING METLIFE REGARDING A COMPLAINT, YOU FEEL THAT A SATISFACTORY RESOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA INSURANCE DEPARTMENT AT:

CALIFORNIA DEPARTMENT OF INSURANCE
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013
1-800-927-4357 (within California)
1-213-897-8921 (outside California)

Georgia residents please be advised of the following:

IMPORTANT NOTICE

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

IMPORTANT NOTICE

NOTICE FOR RESIDENTS OF MONTANA

If a claim on your life or your Dependent's life becomes payable under this certificate, settlement of the claim shall be made within 60 days of the date that we receive proof of death that is satisfactory to us. The settlement shall include interest from the 30th day after we receive such proof until settlement. Such interest shall be paid at the rate required by law in Montana.

Utah residents please be advised of the following:

NOTICE TO POLICYHOLDERS

Insurance companies licensed to sell life insurance, health insurance, or annuities in the State of Utah are required by law to be members of an organization called the Utah Life and Health Insurance Guaranty Association ("ULHIGA"). If an insurance company that is licensed to sell insurance in Utah becomes insolvent (bankrupt), and is unable to pay claims to its policyholders, the law requires ULHIGA to pay some of the insurance company's claims. The purpose of this notice is to briefly describe some of the benefits and limitations provided to Utah insureds by ULHIGA.

PEOPLE ENTITLED TO COVERAGE

- You must be a Utah resident.
- You must have insurance coverage under an individual or group policy.

POLICIES COVERED

- ULHIGA provides coverage for certain life, health and annuity insurance policies.

EXCLUSIONS AND LIMITATIONS

Several kinds of insurance policies are specifically excluded from coverage. There are also a number of limitations to coverage. The following are not covered by ULHIGA:

- Coverage through an HMO.
- Coverage by insurance companies not licensed in Utah.
- Self-funded and self-insured coverage provided by an employer that is only administered by an insurance company.
- Policies protected by another state's Guaranty Association.
- Policies where the insurance company does not guarantee the benefits.
- Policies where the policyholder bears the risk under the policy.
- Re-insurance contracts.
- Annuity policies that are not issued to and owned by an individual, unless the annuity policy is issued to a pension benefit plan that is covered.
- Policies issued to pension benefit plans protected by the Federal Pension Benefit Guaranty Corporation.
- Policies issued to entities that are not members of the ULHIGA, including health plans, fraternal benefit societies, state pooling plans and mutual assessment companies.

LIMITS ON AMOUNT OF COVERAGE

Caps are placed on the amount ULHIGA will pay. These caps apply even if you are insured by more than one policy issued by the insolvent company. The maximum ULHIGA will pay is the amount of your coverage or $500,000 — whichever is lower. Other caps also apply:

- $100,000 in net cash surrender values.
- $500,000 in life insurance death benefits (including cash surrender values).
- $500,000 in health insurance benefits.
- $200,000 in annuity benefits — if the annuity is issued to and owned by an individual or the annuity is issued to a pension plan covering government employees.
- $5,000,000 in annuity benefits to the contract holder of annuities issued to pension plans covered by the law. (Other limitations apply).
- Interest rates on some policies may be adjusted downward.

DISCLAIMER

PLEASE READ CAREFULLY:

- **COVERAGE FROM ULHIGA MAY BE UNAVAILABLE UNDER THIS POLICY. OR, IF AVAILABLE, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS OR EXCLUSIONS. THE DESCRIPTION OF COVERAGES CONTAINED IN THIS DOCUMENT IS AN OVERVIEW. IT IS NOT A COMPLETE DESCRIPTION. YOU CANNOT RELY ON THIS DOCUMENT AS A DESCRIPTION OF COVERAGE. FOR A COMPLETE DESCRIPTION OF COVERAGE, CONSULT THE UTAH CODE, TITLE 31A, CHAPTER 28.**
- **COVERAGE IS CONDITIONED ON CONTINUED RESIDENCY IN THE STATE OF UTAH.**
- **THE PROTECTION THAT MAY BE PROVIDED BY ULHIGA IS NOT A SUBSTITUTE FOR CONSUMERS' CARE IN SELECTING AN INSURANCE COMPANY THAT IS WELL-MANAGED AND FINANCIALLY STABLE.**
- **INSURANCE COMPANIES AND INSURANCE AGENTS ARE REQUIRED BY LAW TO GIVE YOU THIS NOTICE. THE LAW DOES, HOWEVER, PROHIBIT THEM FROM USING THE EXISTENCE OF ULHIGA AS AN INDUCEMENT TO SELL YOU INSURANCE.**
- **THE ADDRESS OF ULHIGA, AND THE INSURANCE DEPARTMENT ARE PROVIDED BELOW.**

Utah Life and Health Insurance
Guaranty Association
955 E. Pioneer Rd.
Draper, Utah 84114

Utah Insurance Department
State Office Building, Room 3110
Salt Lake City, Utah 84114

Virginia residents please be advised of the following:

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact the insurance company issuing this insurance at the following address and telephone number:

Metropolitan Life Insurance Company
1 Madison Avenue
New York, New York 10010
Attn: Corporate Customer Relations Department

To phone in a claim related question, you may call Claims Customer Service at:

1-800-638-5433

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23209

1-800-552-7945 - In-state toll-free
1-804-786-3741 - Out-of-state

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Wisconsin residents please be advised of the following:

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

Metropolitan Life Insurance Company
Corporate Consumer Relations Department
1 Madison Avenue
New York, NY 10010
1-800-638-5433

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517 outside of Madison or 266-0103 in Madison.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS
(Also see SCHEDULE SUPPLEMENT)

The following Benefits are provided subject to the provisions below.

BENEFITS (EMPLOYEE ONLY)	**AMOUNT**
LIFE	An amount equal to 1.5 times your Benefit Pay , as determined by your Employer, rounded to the next higher $1.00
Minimum Life Benefit	$36,000
Maximum Life Benefit	$50,000
ACCIDENTAL DEATH OR DISMEMBERMENT	An amount equal to your Life Benefits

BENEFITS (DEPENDENTS ONLY) **AMOUNT**

OPTIONAL DEPENDENT LIFE

All Employees who elect Option A, B, C, or D

	Options:			
	A	**B**	**C**	**D**
Spouse	$5,000	$10,000	$15,000	$20,000
Child	$1,000	$2,000	$3,000	$4,000

INCREASES AND DECREASES IN AMOUNTS OF LIFE BENEFITS AND ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS

Your earnings on the date you become covered under This Plan will determine your benefits on that date. Any increase or decrease in your benefits will take place on the date of change in your earnings provided you are Actively at Work on that date. If you are not Actively at Work on the date of change in your earnings, the change in your benefits will take place when you return to Active Work.

IF YOU ARE AGE 65 OR OLDER

The amounts of your Life and Accidental Death or Dismemberment Benefits on or after age 65 will reduce by 1.1 percent each month and continue until your benefit is 1/3 of the original amount of insurance in effect the day before your 65th birthday. The reductions begin on the 1st of the month following your 65th birthday, with each additional reduction effective on the first day of each subsequent month of your employment.

WHEN YOU RETIRE

If you retired prior to January 1, 1992

If you retired with at least 10 years of eligible service, as determined by the Employer, your Basic Life benefits will continue.

If you retired before age 62, the amount of your Basic Life Benefit continues in full until the first day of the month following your 62nd birthday. At that point your benefit amount reduces by 5%. This same dollar reduction will continue each month until your benefit amount is the greater of one-third of the amount of your Basic Life Benefit in effect on your 62nd birthday or $2,500.

If you retired on or after age 62, the amount of your Basic Life Benefit reduces by 5% on the date of retirement. This same dollar reduction continues each month until your benefit amount is the greater of one-third of the amount of your Basic Life Benefit in effect on your date of retirement or $2,500.

If you retired on or after January 1, 1992 and prior to January 1, 2000

If you have been participating in the plan since December 31, 1991, and you retired with at least 10 years of eligible service, as determined by the Employer, your Basic Life Benefit will continue.

If your retired before age 62, the amount of your Basic Life Benefit will continue in full until the first day of the month following your 62nd birthday. At that point your benefit amount will reduce by 5%. This same dollar reduction will continue each month until your benefit amount is the greater of one-third of the amount of your Basic Life Benefit in effect on December 31, 1991, or $7,500.

If you retired on or after age 62, the amount of your Basic Life Benefit in effect on the day preceding the date of your retirement will reduce by 5% on the fist day of the month of your retirement. This same dollar reduction will continue each month until your benefit amount is the greater of one-third of the amount of your Basic Life Benefit in effect on December 31, 1991, or $7,500.

If you have not been participating in the plan since December 31, 1991, and you retired with at least 10 years of eligible service, as determined by the Employer, the amount of your Basic Life Benefit will be $7,500 on and after the day you retired.

If you retired on or after January 1, 2000

Basic Life Benefits are provided under This Plan on and after the day you retire with 10 years of eligibility service. The amount of your Basic Life Benefits will be $5,000.

If you Retire directly from active service with the Employer with at least 5 but less than 10 years of Eligibility service

No benefits are provided under This Plan on or after the day you retire.

No other benefits are provided under This Plan on or after the day you retire.

Form G.23000-B

SCHEDULE SUPPLEMENT

A. Statements Made by You Which Relate to Insurability

Any statement made by you will be deemed a representation and not a warranty.

No such statement made by you which relates to insurability will be used:

1. in contesting the validity of the benefits with respect to which such statement was made; or
2. to reduce the benefits;

unless the conditions listed in items (a) and (b) below have been met:

   a. The statement must be contained in a written application which has been signed by you.

   b. A copy of the application has been furnished to you or to your Beneficiary.

No such statement made by you will be used at all after such benefits have been in force prior to the contest for a period of two years during the lifetime of the person to whom the statement applies.

B. Assignment

The benefits with respect to the Life Benefits (On Your Own Account) and the Accidental Death or Dismemberment Benefits under This Plan may be assigned as a gift. The benefits with respect to the Life Benefits (On Your Own Account) are also assignable by means of a viatical assignment. Any such assignment will transfer all right, title, interest and incidents of ownership, both present and future, in such benefits, including, but not limited to, the following:

1. The right to make any contributions required to keep the benefits in force under This Plan.
2. The privilege of obtaining an individual policy of life insurance.
3. The right to change the Beneficiary.

No assignment will be binding on us nor on the Employer unless the following conditions are met:

1. The assignment is in a form which is acceptable to us and to the Employer.
2. The assignment is accepted, in writing, by us and by the Employer.
3. The assignment is filed at our Home Office.

We assume no obligation as to the validity or the sufficiency of any assignment; neither does the Employer.

C. Additional Provisions

1. The benefits under This Plan do not at any time provide paid-up insurance, or loan or cash values.
2. No agent has the authority:

   a. to accept or to waive the required notice or proof of a claim; nor

b. to extend the time within which a notice or a proof must be given to us.

Form G.23000-B1

DEFINITIONS OF CERTAIN TERMS USED HEREIN

"Actively at Work" or **"Active Work"** means that you are performing all of the material duties of your job with the Employer where these duties are normally carried out. If you were Actively at Work on your last scheduled working day, you will be deemed Actively at Work:

1. on a scheduled non-working day;

2. provided you are not disabled.

"Benefit Pay" is the base pay as of September 1 of the year prior to the year for which you are enrolling. For Salaried Employees, Benefit Pay is the monthly base rate as of September 1 times 12 months. For Hourly Employees, Benefit Pay is the base hourly rate as of September 1 times 2,080 hours. For new hires, Benefit Pay is the base pay on the date of hire.

1. Salaried Base Pay: Base pay, excluding bonus and incentives.

2. Hourly Base Pay: Annualized hourly rate, excluding bonuses, incentives, shift differentials and overtime.

Benefit Pay will not change during the Plan Year even if pay changes, except if an employee moves from part-time employment to full-time employment, or vice versa.

"Casual Employee" means an employee who is hired either:

1. for a predetermined limited period of time, usually not longer than two or three months; or,

2. for the purpose of completing a specific task that is anticipated not to exceed five months, and who has no expectation of continued employment beyond completion of that task.

The determination of who is a Casual Employee shall be made on a uniform and nondiscriminatory basis.

Casual Employees include summer students, interns, and co-op students who alternate periods of full-time employment with periods of full-time study.

"Covered Person" means an Employee on whose account benefits are in effect under This Plan.

"Dependent" means your spouse or your unmarried child except for:

1. a person who is in the military or like forces of any country or of any subdivision of a country;

2. a person who is covered under This Plan as an Employee;

3. a person who lives outside the United States or Canada;

4. an unborn or stillborn child; or

5. a child who:

a. is 19 years of age or older and who is employed on a full-time basis; or

b. is 21 years of age or older and who is not a full-time student at an approved school, as determined by the Employer; or

c. is 25 years of age or older.

If a Dependent child is a Covered Person on the day before that child has reached the applicable age limit, that child will continue to be a Dependent after the age limit as long as:

a. that child is and remains unable to work in self-sustaining employment because of:

i. physical handicap; or

ii. mental retardation; and

b. that child is and remains chiefly dependent upon you for support; and

c. that child is and remains a Dependent, as defined, except for the age limit; and

d. you give us proof, when we ask for it, that the child is and remains so unable to work and dependent upon you since the age limit. We will not ask for proof more than once a year. The proof must be satisfactory to us; and

e. you make any payment which is required by the Employer.

Child includes:

a. a child who is supported solely by you and permanently living in the home of which you are the head; and

b. a child who is legally adopted or placed for adoption; and

c. a stepchild who lives in your home; and

d. a child for whom benefits must be provided by court order, that we have been notified of (as set forth in a divorce decree).

No person may be covered as a Dependent of more than one Employee.

"Dependent Benefits" mean the benefits which are provided on account of a Dependent under This Plan.

"Doctor" means a person who is legally licensed to practice medicine. A licensed practitioner will be considered a Doctor if:

1. there is a law which applies to This Plan and that law requires that any service performed by such a practitioner must be considered for benefits on the same basis as if the service were performed by a Doctor; and

2. the service performed by the practitioner is within the scope of his or her license.

"Employee" means a person who is employed and paid for services by the Employer on a Full-Time basis. Employee does not include Part-Time and Casual Employees and Employees in excluded units, as determined by the Employer.

An individual hired through a temporary agency, a contract, or any other arrangement, who is not coded as an employee on the employer's payroll records, is not an Employee. This rule applies even if a court or administrative agency determines that the individual is a "leased employee" under the Internal Revenue Code, or is an employee under common law or other legal standards..

"Employer" means Westinghouse Government Services Group or any subsidiary or affiliate that, by action of its Board of Directors and with the approval of the Board of Directors of Westinghouse, adopts the Plan and this Policy.

"Full-Time Employee" means a person who is regularly scheduled to work more than 32 hours per week for an Employer.

"Hospitalized" means that your Dependent has received:

1. inpatient care in a hospital; or

2. care in:

- **a.** a hospice facility; or
- **b.** an intermediate facility; or
- **c.** a long term care facility; or

3. chemotherapy; or

4. radiation therapy; or

5. dialysis treatment.

"Layoff" means your employment ends through no fault of your own for lack of work for reasons related to the business, and the Employer determines there is a reasonable expectation of recall within one year.

"Normal Activities" means that your Dependent:

1. is not confined in a hospital; or

2. is not confined at home under the care of a Doctor for a sickness or injury; or

3. is not receiving and is not entitled to receive any disability income from any source due to any sickness or injury.

"Permanent Job Separation; Permanent Separation" means when your employment ends through no fault of your own for lack of work for reasons related to the business and Westinghouse has no reasonable expectation of re-employment. You are not considered to be permanently separated if you are offered continued employment by:

1. The Employer:

2. A subsidiary of the Employer;

3. A Successor employer;

4. Any employer at least 50% owned by an Employer; or

5. Any employer partly owned by an Employer that participates in the Westinghouse Government Services Group Pension Plan.

"Personal Benefits" mean the benefits which are provided on account of an Employee under This Plan.

"Qualifying Events" means a change in your family, status due to one or more of the following:

1. changes in Your legal marital status, such as by marriage, divorce, legal separation, death of spouse or annulment;

2. change in the number of Your dependents, such as by birth, adoption, placement for adoption or death of a dependent;

3. changes in the employment status of You, Your spouse or Your dependent child if it causes You, Your spouse or Your dependent child to gain or lose eligibility for insurance;

4. changes in the work schedule of You, Your spouse or Your dependent child if it causes You, Your spouse or Your dependent child to gain or lose eligibility for insurance; and

5. Your dependent's ceasing to be a Dependent as defined under This Plan.

"This Plan" means the Group Policy which is issued by us to provide Personal Benefits.

"We", **"us"** and **"our"** mean Metropolitan.

"You" and **"your"** mean the Employee who is a Covered Person for Personal Benefits.

Form G.23000-A

ELIGIBILITY FOR BENEFITS

Personal Benefits Eligibility Date

Your Personal Benefits Eligibility Date is the later of:

1. January 1, 2004; and

2. the first day of the calendar month after the date you complete 30 days of continuous service as an Employee of the Employer.

Dependent Benefits Eligibility Date

Your Dependent Benefits Eligibility Date is the later of your Personal Benefits Eligibility Date and the date you first acquire a Dependent.

Form G.23000-C

EFFECTIVE DATES OF PERSONAL BENEFITS

Your Personal Benefits will become effective on your Personal Benefits Eligibility Date provided you are then Actively at Work as an Employee. If you are not then Actively at Work as an Employee, your Personal Benefits will become effective on the date of your return to Active Work as an Employee.

Application of Provisions

The provisions for EFFECTIVE DATES OF PERSONAL BENEFITS are to be separately applied to each type of Personal Benefits.

Form G.23000-D1

EFFECTIVE DATES OF DEPENDENT BENEFITS

A. Making a Request for Benefits

1. In order to become insured for Dependent Benefits under This Plan, you must contact the Westinghouse Benefits Center and enroll.

Requests to be insured for Dependent Benefits or a request for change(s) in Dependent Benefits may be made at any time.

2. If you make a request to be insured for Dependent Benefits within thirty-one days of the date your enrollment notice was generated, your Dependent Benefits will become effective, subject to the Additional Requirements, and, on the latest of:

a. your Dependent Benefits Eligibility Date; and

b. the effective date of your Personal Benefits; and

c. the date the information on the enrollment form related to such Dependent is accepted by us as satisfactory.

3. If you make a request to be insured for Dependent Benefits or a request for change(s) in Dependent Benefits within thirty-one days of a Qualifying Event, your Dependent Benefits or the change(s) in the Dependent Benefits will become effective on the latest of:

a. the date of the Qualifying Event;

b. the effective date of your Personal Benefits; and

c. the date of your request;

subject to the Additional Requirements, and provided that the change in coverage is consistent with your new family status.

4. If you make a request to be insured for Dependent Benefits:

a. after 31 days of the date your enrollment notice was generated; or

b. after electing no coverage at the initial eligibility date; then

evidence of the good health of each such Dependent must be given to us.

B. Making a Request for Change to Benefits

1. A request for an increase in your Dependent Benefits may be made at any time. Evidence of good health must be given to us if the request is not made during an enrollment period as communicated by the Employer, or if no Qualifying Event has occurred. The increase will become effective on the first day of the month following the date the evidence of the good health of such Dependent is accepted by us as satisfactory.

Proof is satisfactory only if we determine, in our discretion, that the proof provided establishes that you are entitled to benefits under This Plan.

2. If a request for an increase in your Dependent Benefits is made during an enrollment period, as communicated by the Employer, then Evidence of good health may be required if the request is greater than a one option level increase.

3. A request for a decrease in your Dependent Benefits may be made at any time. The decrease will be effective the first day of the month following such request.

C. Additional Requirements

If, on the date you would have become insured under This Plan for Life Benefits (On Account of Dependents), a Dependent:

1. has been Hospitalized in the last three months prior to the date you make a request for Dependent Benefits under This Plan;

2. is then Hospitalized; or

3. is not then able to perform Normal Activities;

then evidence of the good health of each such Dependent must be given to us.

D. Evidence of Good Health

The evidence of good health is to be given at your expense. Your Dependent Benefits will become effective for each such Dependent for whom evidence of good health must be given to us on the later of:

1. the date the evidence of the good health of such Dependent is accepted by us as satisfactory; and

2. the effective date of your Personal Benefits.

If the evidence of the good health of any person is not accepted by us as satisfactory, such person:

1. will be deemed not to be a Dependent for the purpose of Dependent Benefits; and

2. will not be covered for Dependent Benefits.

E. Reinstatement of Benefits

If your Dependent Benefits end because you do not make a required contribution to their cost, you may make a request to reinstate them, subject to the foregoing provisions.

F. New Dependents

If you are insured for Dependent Benefits and acquire a new Dependent, such event may be considered, subject to the provisions of the flexible benefits plan, as a Qualifying Event. The effective date of Dependent Benefits with respect to such person who becomes your Dependent would be determined in accordance with the foregoing provisions.

Form G.23000-D2

LIFE BENEFITS
(On Your Own Account)

A. Coverage

If you die while you are covered for Life Benefits, we will pay to the Beneficiary the amount of Life Benefits that is in effect on your life on the date of your death.

B. Optional Types of Payment

Payment of any amount of Life Benefits may be made in installments. Details on the payment options may be obtained from the Employer.

Form G.23000-1

LIFE BENEFITS
(On Account of Dependents)

A. Coverage

If a Dependent dies while Life Benefits are in effect for that Dependent, we will pay the amount of Life Benefits that is in effect for that Dependent on the date of that Dependent's death.

B. Payment of Benefits

The benefits will be paid to you if you survive the Dependent. The benefits will be paid to your estate if:

1. that Dependent dies at the same time your death occurs; or
2. that Dependent dies within 24 hours of your death.

In any other instance the benefits will be paid to the Dependent's estate; or we may instead pay all or part of the benefits to one or more of the following persons who are related to that Dependent and who survive that Dependent.

a. surviving spouse;

b. if there is no surviving spouse, to the employee's surviving children in equal shares;

c. if there are no surviving children, to the surviving parents of the employee in equal shares.

d. if there are no surviving parents, to the employee's surviving brothers or sisters in equal shares; and

e. if there are no surviving brothers or sisters, to your estate.

If there is no surviving relative, the amount will be payable to the Dependent's estate.

Any payment will discharge our liability for the amount so paid.

C. Optional Types of Payment

Payment of any amount of Life Benefits may be made in installments instead of one sum. Details on the payment options may be obtained from the Employer.

Form G.23000-7C

RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON YOUR OWN LIFE

A. Application

We will issue a personal policy of life insurance without disability or accidental death benefits to you if you apply for it in writing during the Application Period. The Application Period is the 31 day period after:

1. the date your Life Benefits end because your employment ends or because you are no longer in a class which remains eligible for Life Benefits; or

2. the date your Life Benefits end because This Plan ends, but only if your Life Benefits under This Plan have been in effect for at least 5 years; or

3. the date This Plan is changed to end the Life Benefits for your class, but only if your Life Benefits under This Plan have been in effect for at least 5 years.

4. the date your Life Benefits end because of your employment with a Successor employer.

For New Hampshire residents. If you are not given notice, in writing, of the Right To Obtain A Personal Policy of Life Insurance On Your Own Life at least 15 days before the end of the Application Period, you will have additional time in which to apply. You will then have 15 days from the date you are given the notice in which to apply.

Proof that you are insurable is not required by us.

B. Conditions

The personal policy will be issued to you subject to these conditions:

1. it will be on one of the forms then usually issued by us, except term insurance; and

2. it will not take effect until after the Application Period ends; and

3. the premium for the policy will be based on:

a. the class of risk to which you belong; and

b. your age on the effective date of the policy; and

c. the form and amount of the policy; and

4. if item A(1) applies to you, the amount of the policy will not be more than the amount of your Life Benefits on the date the Life Benefits end; and

5. if item A(2) or item A(3) applies to you, the amount of the policy will not be more than the lesser of:

a. the amount of your Life Benefits on the date the Life Benefits end, less any amount of life insurance for which you may be eligible under any group policy which takes effect within 31 days after your Life Benefits end; and

b. $2,000*.

*For New Hampshire residents this amount is $10,000.

C. If You Die During the Application Period

If you die during the Application Period, we will pay a death benefit to the Beneficiary. The amount of the death benefit will be the highest amount of life insurance pursuant to item B(4) or B(5) for which a personal policy could have been issued. This death benefit will be paid even if you did not apply for a personal policy.

Form G.23000-1A

RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON THE LIFE OF A DEPENDENT

A. Application

We will issue a personal policy of life insurance without disability or accidental death benefits to a Dependent if that Dependent applies for it in writing during the Application Period. The Application Period is the 31 day period after the date the Life Benefits on that Dependent end because:

1. your employment ends or you are no longer in a class which remains eligible for Dependent Life Benefits; or
2. This Plan ends, but only if the Life Benefits on that Dependent had been in effect under This Plan for at least 5 years; or
3. This Plan is changed to end the Dependent Life Benefits for your class, but only if the Life Benefits on that Dependent had been in effect under This Plan for at least 5 years; or
4. you die; or
5. the Dependent no longer qualifies as a Dependent as defined in DEFINITIONS OF CERTAIN TERMS USED HEREIN.

For New Hampshire residents. If the Dependent is not given notice, in writing, of the Right To Obtain A Personal Policy of Life Insurance On The Life of A Dependent at least 15 days before the end of the Application Period, that Dependent will have additional time in which to apply. The Dependent will then have 15 days from the date the Dependent is given the notice in which to apply.

Proof that the Dependent is insurable is not required by us.

B. Conditions

The personal policy will be issued to the Dependent subject to these conditions:

1. it will be on one of the forms then usually issued by us, except term insurance; and
2. it will not take effect until after the Application Period ends; and
3. the premium for the policy will be based on:
   a. the class of risk to which the Dependent belongs; and
   b. the Dependent's age on the effective date of the policy; and
   c. the form and the amount of the policy; and

4. if item A(2) or A(3) applies to the Dependent, the amount of the policy will not be more than the lesser of:

   a. the amount of Life Benefits on that Dependent on the date the Life Benefits end, less any amount of life insurance on the life of that Dependent for which you or the Dependent may be eligible under any group policy which takes effect within 31 days after the Life Benefits on that Dependent end; and

   b. $2,000*; and

*For New Hampshire residents this amount is $10,000.

5. if an item in paragraph A, other than item A(2) or A(3), applies to the Dependent, the amount of the policy will not be more than the amount of Life Benefits on that Dependent on the date the Life Benefits end.

C. If the Dependent Dies During the Application Period

If the Dependent dies during the Application Period, we will pay a death benefit. The payment of the death benefit will be in the same manner as if the Life Benefits on that Dependent had been in effect on the date of that Dependent's death. The amount of the death benefit will be the highest amount of life insurance, pursuant to item B(4) or B(5) for which a personal policy could have been issued. This death benefit will be paid even if the Dependent did not apply for a personal policy.

Form G.23000-7A

ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS

A. Coverage

We will pay Accidental Death or Dismemberment Benefits for a Covered Loss shown in Section C if you are injured in an accident which occurs while you are covered for Accidental Death or Dismemberment Benefits; and if:

1. that accident is the sole cause of the injury; and

2. that injury is the sole cause of that Covered Loss.

B. Maximum Benefit for All Covered Losses in Each Accident

For all Covered Losses caused by all injuries which you sustain in one accident not more than the Full Amount will be paid.

E. Payment of Benefits

The Accidental Death or Dismemberment Benefits for a Covered Loss will be paid when we receive notice and satisfactory proof of that loss.

Accidental Death or Dismemberment Benefits will be paid:

1. to your Beneficiary for the loss of your life; and

2. to you for any other Covered Loss sustained by you.

F. Optional Types of Payment

Payment of any amount of Accidental Death or Dismemberment Benefits for loss of life may be made in installments. Details on the payment options may be obtained from the Employer.

Form G.23000-4L

BENEFICIARY

A. Your Beneficiary

The "Beneficiary" is the person or persons you choose to receive any benefit payable because of your death.

You make your choice in writing on a form approved by us. This form must be filed with the records for This Plan.

Unless you have assigned your benefits under this Plan, you may change the Beneficiary at any time by filing a new form with the Employer. You do not need the consent of the Beneficiary to make a change. When the Employer receives a form changing the Beneficiary, the change will take effect as of the date you signed it. The change of Beneficiary will take effect even if you are not alive when it is received.

A change of Beneficiary will not apply to any payment made by us prior to the date the form was received by the Employer.

Your choice of a Beneficiary for a personal policy issued under RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON YOUR OWN LIFE will be effective for This Plan.

B. More Than One Beneficiary

If, when you die, more than one person is your Beneficiary, they will share in the benefits equally, unless you have chosen otherwise.

C. Death of a Beneficiary

A person's rights as a Beneficiary end if:

1. that person dies before your death occurs; or

2. that person dies at the same time your death occurs; or

3. that person dies within 24 hours of your death.

The share for that person will be divided among the surviving persons you have named as Beneficiary, unless you have chosen otherwise.

D. No Beneficiary at Your Death

If there is no Beneficiary at your death for any amount of benefits payable because of your death, that amount will be paid to one or more of the following persons who are related to you and who survive you:

a. surviving spouse;

b. if there is no surviving spouse, to the employee's surviving children in equal shares;

c. if there are no surviving children, to the surviving parents of the employee in equal shares;

d. if there are no surviving parents, to the employee's surviving brothers or sisters in equal shares; and

e. if there are no surviving brothers or sisters, to your estate.

If there is no surviving relative in any class, that amount will be payable to your estate.

Any payment will discharge our liability for the amount so paid.

Form G.23000-G

CLAIM PROCEDURE FOR ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS

A. When Notice of Claim Must be Given

Written notice of a claim must be given to us for Accidental Death or Dismemberment Benefits within 20 days after the date of the accident which caused the loss.

B. Claim Forms

When we receive written notice of a claim, we may furnish printed forms for filing proof of the claim. If we do not furnish printed forms within 15 days after you give us notice, you must furnish your own form of proof in writing.

Proof must describe the event, the nature and the extent of the cause for which a claim is made; it must be satisfactory to us.

Proof is satisfactory only if we determine, in our discretion, that the proof provided establishes that you are entitled to benefits under This Plan.

C. When Proof of Claim Must Be Given

Written proof of a claim must be given to us not later than 90 days after the date of the loss, in the case of Accidental Death or Dismemberment Benefits.

D. Late Notice or Proof

If notice or proof is not given on time, the delay will not cause a claim to be denied or reduced as long as the notice or proof is given as soon as possible.

E. Time Limits on Starting Lawsuits

No lawsuit may be started to obtain benefits until 60 days after proof is given.

No lawsuit may be started more than 3 years after the time proof must be given.

No lawsuit may be brought regarding an individual coverage or eligibility for benefits until the individual has exhausted his administrative remedies under the Westinghouse Welfare Benefits Plan.

F. Medical Examinations

While a claim is pending, we, at our expense, have the right to have you examined by Doctors of our choice when and as often as we reasonably choose.

G. Autopsy

If Accidental Death or Dismemberment Benefits are claimed, we, at our expense, have, in the case of death, the right to have an autopsy made where it is not against the law.

Form G.23000-H3

WHEN BENEFITS END

A. All of your benefits will end on your last day worked. However, for the purpose of benefits, the Employer may deem your employment to continue for certain absences. See CONDITIONS UNDER WHICH YOUR ACTIVE WORK IS DEEMED TO CONTINUE.

B. If This Plan ends in whole or in part, your benefits which are affected will end.

C. Your Dependent Life Benefits will end on the earliest of:

1. the date that the Dependent ceases to be your Dependent; or

2. the date you retire, as determined by the Employer; or

3. the date of your death.

D. If a Covered Person does not make a payment which is required by the Employer to the cost of any benefits, those benefits will end; they will end on the last day of the period for which a payment required by the Employer was made.

E. If you have less than twenty-five years of eligible service and you accept employment with a successor employer, your benefits end on the date of sale. If you have twenty-five years of eligible service or more and you accept continued employment with a successor employer, your benefits are described under CONDITIONS UNDER WHICH YOUR ACTIVE WORK IS DEEMED TO CONTINUE.

The end of any type of benefits on account of a Covered Person will not affect a claim which is incurred before those benefits ended.

Form G.23000-F

CONDITIONS UNDER WHICH YOUR ACTIVE WORK IS DEEMED TO CONTINUE

If you are not Actively at Work as an Employee because of a situation set forth below, the Employer may deem you to be in Active Work as an Employee only for the purpose of continuing your employment and only for the periods specified below in order that certain of your benefits under This Plan may be continued.

All such benefits will be subject to prior cessation as set forth in WHEN BENEFITS END.

In any case, the benefits will end on:

1. the date the Employer notifies us that your benefits are not to be continued; or

2. the end of the last period for which the Employer has paid premiums to us for your benefits.

Your Sickness or Injury, Your Leave of Absence, Your Lay Off or Permanent Job Separation

With respect to all Personal and Dependent Benefits, the period determined in accordance with the Employer's general practice for an Employee in your job class.

However, in the event the leave qualifies under the Family and Medical Leave Act of 1993 (FMLA), the period cannot be longer than 12 weeks in any 12 month period following the date the leave of absence begins.

Your Total Disability

If you become totally disabled prior to your 65th birthday and have at least 10 years of eligibility service, your Basic Life Benefits will continue past your 65th birthday, as long as you remain totally disabled. Benefits will reduce monthly by 5%, beginning on the 1st of the month after your 65th birthday. Reductions will continue until the Basic Life Benefit is 1/3 of the amount in effect on the day before your 65th birthday, or $2,500, whichever is more.

If you are totally disabled and your disability begins before age 65 and you have at least one year, but less than 10 years of Eligibility service, your Basic Life Benefits will continue. Your Benefits will continue up to the 1st of the month after your 65th birthday, as long as you remain totally disabled.

If you are totally disabled and your disability begins on or after age 65 or you have less than one year of Eligibility service, your Basic Life Benefits will continue up to one year from your last day worked, as long as you remain totally disabled.

To continue receiving these benefits, you must submit proof of your continuing total disability when asked.

If you become totally disabled, your Accidental Death or Dismemberment Benefits will continue for 12 months as long as you remain totally disabled.

If you become totally disabled, your Dependent Life Benefits continue for up to 12 months as long as you remain totally disabled. No contributions are required for this period after your salary or wages stop.

Your Employment with a Successor Employer if you have 25 or more years of service

If you have twenty-five or more years of service and you accept continued employment with a successor employer, your benefits will be as follows:

Salaried Employees will receive a Life Benefit equal to 75% of your Basic Life benefit in effect on the day before you accept continued employment with the successor employer, rounded to the next higher $1,000, to a maximum of $37,500. On the day you reach age 62, your benefits will continue, but will immediately reduce to $3,750.

Hourly Employees will receive a Life Benefit equal to 75% of your Basic Life benefit in effect on the day before you accept continued employment with the successor employer, rounded to the next higher $1,000, to a maximum of $32,250. On the day you reach age 62, your benefits will continue, but will immediately reduce to $3,225.

Dependent Life Benefits can be continued as long as premium is submitted and you have an eligible Dependent.

Your Retirement

With respect to all Personal Benefits on and after the date of your retirement, for the period determined in accordance with the Employer's general practices for an Employee in your job class.

Form G.23000-L

NOTICES

This certificate is of value to you. It should be kept in a safe place. Your Beneficiary should know where the certificate is kept.

As soon as your benefits end, you should consult your Employer to find out what rights, if any, you may have to continue your protection.

Our Home Office is located at One Madison Avenue, New York, New York 10010.

Form G.23000-E

THIS IS THE END OF THE CERTIFICATE. THE FOLLOWING IS ADDITIONAL INFORMATION.

CLAIMS INFORMATION

Procedures for Presenting Claims for Life and Accidental Death or Dismemberment Benefits

All claim forms needed to file for benefits under the group insurance program can be obtained from the Employer who will also be ready to answer questions about the insurance benefits and to assist you or, if applicable, your beneficiary in filing claims.

Life and Accidental Death or Dismemberment Benefits Claims

Routine Questions

If there is any question about a claim payment, an explanation may be requested from the Employer who is usually able to provide the necessary information.

Claim Submission

In submitting claims for Life and Accidental Death or Dismemberment benefits ("Benefits"), the claimant must complete the appropriate claim form and submit the required proof as described in the certificate.

Claim forms must be submitted in accordance with the instructions on the claim form.

Initial Determination

After MetLife receives your claim for Benefits, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 90 days from the date we received your claim, unless MetLife notifies you within that period that there are special circumstances requiring an extension of time of up to 90 additional days.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Plan review procedures and time limits, including a statement of your right to bring a civil action if your claim is denied after an appeal.

Appealing the Initial Determination

In the event a claim has been denied in whole or in part, you or, if applicable, your beneficiary can request a review of your claim by MetLife. This request for review should be sent in writing to Group Insurance Claims Review at the address of MetLife's office which processed the claim within 60 days after you or, if applicable, your beneficiary received notice of denial of the claim. When requesting a review, please state the reason you or, if applicable, your beneficiary believe the claim was improperly denied and submit in writing any written comments, documents, records or other information you or, if applicable, your beneficiary deem appropriate. Upon your written request, MetLife will provide you free of charge with copies of relevant documents, records and other information.

MetLife will re-evaluate all the information, will conduct a full and fair review of the claim, and you or, if applicable, your beneficiary will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date we received your request for review, unless MetLife notifies you within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied, references any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of your right to bring a civil action if your claim is denied after an appeal. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

YOUR EMPLOYEE BENEFIT PLAN

WESTINGHOUSE GOVERNMENT SERVICES GROUP

Basic Life and Accidental Death or Dismemberment For Part-Time Employees

Westinghouse Government Services Group
4350 Northern Pike
Monroeville, PA 15146-2886

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

This certificate describes the benefits that are available to you. We urge you to read it carefully.

Benefits are provided through a group policy issued to Westinghouse Government Services Group by Metropolitan Life Insurance Company.

Westinghouse Government Services Group

MetLife®

Metropolitan Life Insurance Company
One Madison Avenue, New York, New York 10010-3690

Certifies that, under and subject to the terms and conditions of the Group Policy issued to the Employer, coverage is provided for each Employee as defined herein.

The date when an Employee is eligible for coverage is set forth in the form with the title Eligibility for Benefits.

The date when an Employee's Personal Benefits become effective is set forth in the form with the title Effective Dates of Personal Benefits.

The amounts of coverage are determined by the form with the title Schedule of Benefits.

Robert H. Benmosche
Chairman, President and Chief Executive Officer

Employer: **Westinghouse Government Services Company, LLC, and Westinghouse Government Environmental Services Company, LLC**

Group Policy No.: **96934-G**

Florida Residents: The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida.

For Maryland residents: The group insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

If any prior certificate relating to the coverage set forth herein has been given to the Employee, such certificate is void.

Form G.23000-Cert.-1

For Texas Residents:

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call MetLife's toll-free telephone number for information or to make a complaint at

1-800-638-5433

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
Fax # 512 - 475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact MetLife first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR CERTIFICATE: This notice is for information only and does not become a part or condition of the attached document.

Para Residentes de Texas:

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de MetLife para informacion o para someter una queja al

1-800-638-5433

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas
P.O. Box 149104
Austin, TX 78714-9104
Fax # 512 - 475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con MetLife primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU CERTIFICADO: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

Arkansas residents please be advised of the following:

IMPORTANT NOTICE

IF YOU HAVE A QUESTION CONCERNING YOUR COVERAGE OR A CLAIM, FIRST CONTACT YOUR GROUP EMPLOYER OR GROUP ACCOUNT ADMINISTRATOR. IF, AFTER DOING SO, YOU STILL HAVE A CONCERN, YOU MAY CALL METLIFE'S TOLL-FREE TELEPHONE NUMBER:

1-800-638-5433

IF YOU ARE STILL CONCERNED AFTER CONTACTING BOTH YOUR GROUP EMPLOYER AND METLIFE, YOU SHOULD FEEL FREE TO CONTACT:

ARKANSAS INSURANCE DEPARTMENT
CONSUMER SERVICES DIVISION
1200 WEST THIRD
LITTLE ROCK, ARKANSAS 72201-1904

California residents please be advised of the following:

IMPORTANT NOTICE

TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT METLIFE AT:

METROPOLITAN LIFE INSURANCE COMPANY
1 MADISON AVENUE
NEW YORK, NY 10010
ATTN: CORPORATE CONSUMER RELATIONS DEPARTMENT
1-800-638-5433

IF, AFTER CONTACTING METLIFE REGARDING A COMPLAINT, YOU FEEL THAT A SATISFACTORY RESOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA INSURANCE DEPARTMENT AT:

CALIFORNIA DEPARTMENT OF INSURANCE
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013
1-800-927-4357 (within California)
1-213-897-8921 (outside California)

Georgia residents please be advised of the following:

IMPORTANT NOTICE

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

IMPORTANT NOTICE

NOTICE FOR RESIDENTS OF MONTANA

If a claim on your life becomes payable under this certificate, settlement of the claim shall be made within 60 days of the date that we receive proof of death that is satisfactory to us. The settlement shall include interest from the 30th day after we receive such proof until settlement. Such interest shall be paid at the rate required by law in Montana.

Utah residents please be advised of the following:

NOTICE TO POLICYHOLDERS

Insurance companies licensed to sell life insurance, health insurance, or annuities in the State of Utah are required by law to be members of an organization called the Utah Life and Health Insurance Guaranty Association ("ULHIGA"). If an insurance company that is licensed to sell insurance in Utah becomes insolvent (bankrupt), and is unable to pay claims to its policyholders, the law requires ULHIGA to pay some of the insurance company's claims. The purpose of this notice is to briefly describe some of the benefits and limitations provided to Utah insureds by ULHIGA.

PEOPLE ENTITLED TO COVERAGE

- You must be a Utah resident.
- You must have insurance coverage under an individual or group policy.

POLICIES COVERED

- ULHIGA provides coverage for certain life, health and annuity insurance policies.

EXCLUSIONS AND LIMITATIONS

Several kinds of insurance policies are specifically excluded from coverage. There are also a number of limitations to coverage. The following are not covered by ULHIGA:

- Coverage through an HMO.
- Coverage by insurance companies not licensed in Utah.
- Self-funded and self-insured coverage provided by an employer that is only administered by an insurance company.
- Policies protected by another state's Guaranty Association.
- Policies where the insurance company does not guarantee the benefits.
- Policies where the policyholder bears the risk under the policy.

- Re-insurance contracts.
- Annuity policies that are not issued to and owned by an individual, unless the annuity policy is issued to a pension benefit plan that is covered.
- Policies issued to pension benefit plans protected by the Federal Pension Benefit Guaranty Corporation.
- Policies issued to entities that are not members of the ULHIGA, including health plans, fraternal benefit societies, state pooling plans and mutual assessment companies.

LIMITS ON AMOUNT OF COVERAGE

Caps are placed on the amount ULHIGA will pay. These caps apply even if you are insured by more than one policy issued by the insolvent company. The maximum ULHIGA will pay is the amount of your coverage or $500,000 — whichever is lower. Other caps also apply:

- $100,000 in net cash surrender values.
- $500,000 in life insurance death benefits (including cash surrender values).
- $500,000 in health insurance benefits.
- $200,000 in annuity benefits — if the annuity is issued to and owned by an individual or the annuity is issued to a pension plan covering government employees.
- $5,000,000 in annuity benefits to the contract holder of annuities issued to pension plans covered by the law. (Other limitations apply).
- Interest rates on some policies may be adjusted downward.

DISCLAIMER

PLEASE READ CAREFULLY:

· **COVERAGE FROM ULHIGA MAY BE UNAVAILABLE UNDER THIS POLICY. OR, IF AVAILABLE, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS OR EXCLUSIONS. THE DESCRIPTION OF COVERAGES CONTAINED IN THIS DOCUMENT IS AN OVERVIEW. IT IS NOT A COMPLETE DESCRIPTION. YOU CANNOT RELY ON THIS DOCUMENT AS A DESCRIPTION OF COVERAGE. FOR A COMPLETE DESCRIPTION OF COVERAGE, CONSULT THE UTAH CODE, TITLE 31A, CHAPTER 28.**

· **COVERAGE IS CONDITIONED ON CONTINUED RESIDENCY IN THE STATE OF UTAH.**

· **THE PROTECTION THAT MAY BE PROVIDED BY ULHIGA IS NOT A SUBSTITUTE FOR CONSUMERS' CARE IN SELECTING AN INSURANCE COMPANY THAT IS WELL-MANAGED AND FINANCIALLY STABLE.**

· **INSURANCE COMPANIES AND INSURANCE AGENTS ARE REQUIRED BY LAW TO GIVE YOU THIS NOTICE. THE LAW DOES, HOWEVER, PROHIBIT THEM FROM USING THE EXISTENCE OF ULHIGA AS AN INDUCEMENT TO SELL YOU INSURANCE.**

· **THE ADDRESS OF ULHIGA, AND THE INSURANCE DEPARTMENT ARE PROVIDED BELOW.**

Utah Life and Health Insurance
Guaranty Association
955 E. Pioneer Rd.
Draper, Utah 84114

Utah Insurance Department
State Office Building, Room 3110
Salt Lake City, Utah 84114

Virginia residents please be advised of the following:

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact the insurance company issuing this insurance at the following address and telephone number:

Metropolitan Life Insurance Company
1 Madison Avenue
New York, New York 10010
Attn: Corporate Customer Relations Department

To phone in a claim related question, you may call Claims Customer Service at:

1-800-638-5433

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23209

1-800-552-7945 - In-state toll-free
1-804-786-3741 - Out-of-state

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Wisconsin residents please be advised of the following:

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

Metropolitan Life Insurance Company
Corporate Consumer Relations Department
1 Madison Avenue
New York, NY 10010
1-800-638-5433

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517 outside of Madison or 266-0103 in Madison.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS
(Also see SCHEDULE SUPPLEMENT)

The following Benefits are provided subject to the provisions below.

BENEFITS (EMPLOYEE ONLY)	**AMOUNT**
LIFE	$3,750
ACCIDENTAL DEATH OR DISMEMBERMENT	$3,750

IF YOU ARE AGE 65 OR OLDER

The amount of your Life Benefits on and after age 65 will be reduced by 1.1% on the first day of each month you work beyond age 65. This same dollar reduction will continue each month until your benefit amount is one-third of the amount in effect on the day before your 65th birthday.

WHEN YOU RETIRE

No benefits are provided under This Plan on or after the day you retire.

Form G.23000-B

SCHEDULE SUPPLEMENT

A. Statements Made by You Which Relate to Insurability

Any statement made by you will be deemed a representation and not a warranty.

No such statement made by you which relates to insurability will be used:

1. in contesting the validity of the benefits with respect to which such statement was made; or

2. to reduce the benefits;

unless the conditions listed in items (a) and (b) below have been met:

a. The statement must be contained in a written application which has been signed by you.

b. A copy of the application has been furnished to you or to your Beneficiary.

No such statement made by you will be used at all after such benefits have been in force prior to the contest for a period of two years during the lifetime of the person to whom the statement applies.

B. Assignment

The benefits with respect to the Life Benefits (On Your Own Account) and the Accidental Death or Dismemberment Benefits under This Plan may be assigned as a gift. The benefits with respect to the Life Benefits (On Your Own Account) are also assignable by means of a viatical assignment. Any such assignment will transfer all right, title, interest and incidents of ownership, both present and future, in such benefits, including, but not limited to, the following:

1. The right to make any contributions required to keep the benefits in force under This Plan.

2. The privilege of obtaining an individual policy of life insurance.

3. The right to change the Beneficiary.

No assignment will be binding on us nor on the Employer unless the following conditions are met:

1. The assignment is in a form which is acceptable to us and to the Employer.

2. The assignment is accepted, in writing, by us and by the Employer.

3. The assignment is filed at our Home Office.

We assume no obligation as to the validity or the sufficiency of any assignment; neither does the Employer.

C. Additional Provisions

1. The benefits under This Plan do not at any time provide paid-up insurance, or loan or cash values.

2. No agent has the authority:

   a. to accept or to waive the required notice or proof of a claim; nor

b. to extend the time within which a notice or a proof must be given to us.

Form G.23000-B1

DEFINITIONS OF CERTAIN TERMS USED HEREIN

"Actively at Work" or **"Active Work"** means that you are performing all of the material duties of your job with the Employer where these duties are normally carried out. If you were Actively at Work on your last scheduled working day, you will be deemed Actively at Work:

1. on a scheduled non-working day;

2. provided you are not disabled.

"Casual Employee" means a person who is hired either:

1. for a predetermined limited period of time, usually not longer than two or three months; or.

2. for the purpose of completing a specific task that is anticipated not to exceed five months, and who has no expectation of continued employment beyond the completion of that task.

The determination of who is a Casual Employee shall be made on a uniform and nondiscriminatory basis.

Casual employees include summer students, interns, and co-op students who alternate periods of full-time employment with periods of full-time study.

`**"Covered Person"** means an Employee on whose account benefits are in effect under This Plan.

"Doctor" means a person who is legally licensed to practice medicine. A licensed practitioner will be considered a Doctor if:

1. there is a law which applies to This Plan and that law requires that any service performed by such a practitioner must be considered

for benefits on the same basis as if the service were performed by a Doctor; and

2. the service performed by the practitioner is within the scope of his or her license.

"Employee" means a person who is employed and paid for services by the Employer and is scheduled to work 80% or less of the established number of hours for a location, but not less than 24 hours per week, whether calculated on a daily, weekly, monthly or annual basis. Employee does not include Casual Employees and Employees in excluded units, as determined by the Employer.

An individual hired through a temporary agency, a contract, or any other arrangement, who is not coded as an employee on the employer's payroll records, is not an Employee. This rule applies even if a court or administrative agency determines that the individual is a "leased employee" under the Internal Revenue Code, or is an employee under common law or other legal standards.

"Employer" means Westinghouse Government Services Company, LLC, or Westinghouse Government Environmental Services Company, LLC, or any subsidiary or affiliate that, by action of its Board of Directors, and with the approval of the Board of Directors of Westinghouse, adopts the Plan and this Policy.

"Personal Benefits" mean the benefits which are provided on account of an Employee under This Plan.

"This Plan" means the Group Policy which is issued by us to provide Personal Benefits.

"We", **"us"** and **"our"** mean Metropolitan.

"You" and **"your"** mean the Employee who is a Covered Person for Personal Benefits.

Form G.23000-A

ELIGIBILITY FOR BENEFITS

Personal Benefits Eligibility Date

Your Personal Benefits Eligibility Date is the later of:

1. January 1, 2004; and
2. the first day of the calendar month after the date you complete 30 days of continuous service as an Employee of the Employer.

Form G.23000-C

EFFECTIVE DATES OF PERSONAL BENEFITS

Your Personal Benefits will become effective on your Personal Benefits Eligibility Date provided you are then Actively at Work as an Employee. If you are not then Actively at Work as an Employee, your Personal Benefits will become effective on the date of your return to Active Work as an Employee.

Application of Provisions

The provisions for EFFECTIVE DATES OF PERSONAL BENEFITS are to be separately applied to each type of Personal Benefits.

Form G.23000-D1

LIFE BENEFITS
(On Your Own Account)

A. Coverage

If you die while you are covered for Life Benefits, we will pay to the Beneficiary the amount of Life Benefits that is in effect on your life on the date of your death.

B. Optional Types of Payment

Payment of any amount of Life Benefits may be made in installments. Details on the payment options may be obtained from the Employer.

Form G.23000-1

RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON YOUR OWN LIFE

A. Application

We will issue a personal policy of life insurance without disability or accidental death benefits to you if you apply for it in writing during the Application Period. The Application Period is the 31 day period after:

1. the date your Life Benefits end because your employment ends or because you are no longer in a class which remains eligible for Life Benefits; or

2. the date your Life Benefits end because This Plan ends, but only if your Life Benefits under This Plan have been in effect for at least 5 years; or

3. the date This Plan is changed to end the Life Benefits for your class, but only if your Life Benefits under This Plan have been in effect for at least 5 years.

For New Hampshire residents. If you are not given notice, in writing, of the Right To Obtain A Personal Policy of Life Insurance On Your Own Life at least 15 days before the end of the Application Period, you will have additional time in which to apply. You will then have 15 days from the date you are given the notice in which to apply.

Proof that you are insurable is not required by us.

B. Conditions

The personal policy will be issued to you subject to these conditions:

1. it will be on one of the forms then usually issued by us, except term insurance; and

2. it will not take effect until after the Application Period ends; and

3. the premium for the policy will be based on:

a. the class of risk to which you belong; and

b. your age on the effective date of the policy; and

c. the form and amount of the policy; and

4. if item A(1) applies to you, the amount of the policy will not be more than the amount of your Life Benefits on the date the Life Benefits end; and

5. if item A(2) or item A(3) applies to you, the amount of the policy will not be more than the lesser of:

a. the amount of your Life Benefits on the date the Life Benefits end, less any amount of life insurance for which you may be eligible under any group policy which takes effect within 31 days after your Life Benefits end; and

b. $2,000*.

*For New Hampshire residents this amount is $10,000.

C. If You Die During the Application Period

If you die during the Application Period, we will pay a death benefit to the Beneficiary. The amount of the death benefit will be the highest amount of life insurance pursuant to item B(4) or B(5) for which a personal policy could have been issued. This death benefit will be paid even if you did not apply for a personal policy.

Form G.23000-1A

ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS

A. Coverage

We will pay Accidental Death or Dismemberment Benefits for a Covered Loss shown in Section C if you are injured in an accident which occurs while you are covered for Accidental Death or Dismemberment Benefits; and if:

1. that accident is the sole cause of the injury; and

2. that injury is the sole cause of that Covered Loss.

B. Maximum Benefit for All Covered Losses in Each Accident

For all Covered Losses caused by all injuries which you sustain in one accident not more than the Full Amount will be paid.

Full Amount means the amount of Accidental Death or Dismemberment Benefits for which you are covered on the date of your accident.

C. Table of Covered Losses and Benefit Amounts

Covered Losses (Subject to Exclusions)	**Benefit Amounts**
Life	Full Amount
A hand	One-half of the Full Amount
A foot	One-half of the Full Amount
Sight of an eye	One-half of the Full Amount
Any combination of a hand, a foot or sight of an eye	Full Amount
Quadriplegia	Full Amount
Paraplegia	Full Amount
Hemiplegia	Full Amount

Loss of sight of an eye means that the eye is entirely blind and that no sight can be restored in that eye.

Loss of a hand means that all of the hand is cut off at or above the wrist.

Loss of a foot means that all of the foot is cut off at or above the ankle.

Quadriplegia means total paralysis of both upper and lower limbs.

Paraplegia means total paralysis of both lower limbs.

Hemiplegia means total paralysis of upper and lower limbs on one side of the body.

D. Exclusions

We will not pay for any Covered Loss shown in Section C if it in any way results from, or is caused or contributed to by:

1. physical or mental illness, diagnosis of or treatment for the illness; or

2. an infection, unless it is caused by an external wound that can be seen and which was sustained in an accident; or

3. suicide or attempted suicide; or

4. injuring oneself on purpose; or

5. the use of any drug or medicine voluntarily taken, unless used on the advice of a Doctor; or

6. a war, or a warlike action in time of peace, including terrorist acts; or

7. committing or trying to commit a felony or other serious crime or an assault.

E. Payment of Benefits

The Accidental Death or Dismemberment Benefits for a Covered Loss will be paid when we receive notice and satisfactory proof of that loss.

Accidental Death or Dismemberment Benefits will be paid:

1. to your Beneficiary for the loss of your life; and

2. to you for any other Covered Loss sustained by you.

F. Optional Types of Payment

Payment of any amount of Accidental Death or Dismemberment Benefits for loss of life may be made in installments. Details on the payment options may be obtained from the Employer.

Form G.23000-4L

BENEFICIARY

A. Your Beneficiary

The "Beneficiary" is the person or persons you choose to receive any benefit payable because of your death.

You make your choice in writing on a form approved by us. This form must be filed with the records for This Plan.

Unless you have assigned your benefits under this Plan, you may change the Beneficiary at any time by filing a new form with the Employer. You do not need the consent of the Beneficiary to make a change. When the Employer receives a form changing the Beneficiary, the change will take effect as of the date you signed it. The change of Beneficiary will take effect even if you are not alive when it is received.

A change of Beneficiary will not apply to any payment made by us prior to the date the form was received by the Employer.

Your choice of a Beneficiary for a personal policy issued under RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON YOUR OWN LIFE will be effective for This Plan.

B. More Than One Beneficiary

If, when you die, more than one person is your Beneficiary, they will share in the benefits equally, unless you have chosen otherwise.

C. Death of a Beneficiary

A person's rights as a Beneficiary end if:

1. that person dies before your death occurs; or

2. that person dies at the same time your death occurs; or

3. that person dies within 24 hours of your death.

The share for that person will be divided among the surviving persons you have named as Beneficiary, unless you have chosen otherwise.

D. No Beneficiary at Your Death

If there is no Beneficiary at your death for any amount of benefits payable because of your death, that amount will be paid to one or more of the following persons who are related to you and who survive you:

a. surviving spouse;

b. if there is no surviving spouse, to the employee's surviving children in equal shares;

c. if there are no surviving children, to the surviving parents of the employee in equal shares;

d. if there are no surviving parents, to the employee's surviving brothers or sisters in equal shares; and

e. if there are no surviving brothers or sisters, to your estate.

If there is no surviving relative in any class, that amount will be payable to your estate.

Any payment will discharge our liability for the amount so paid.

Form G.23000-G

CLAIM PROCEDURE FOR ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS

A. When Notice of Claim Must be Given

Written notice of a claim must be given to us for Accidental Death or Dismemberment Benefits within 20 days after the date of the accident which caused the loss.

B. Claim Forms

When we receive written notice of a claim, we may furnish printed forms for filing proof of the claim. If we do not furnish printed forms within 15 days after you give us notice, you must furnish your own form of proof in writing.

Proof must describe the event, the nature and the extent of the cause for which a claim is made; it must be satisfactory to us.

Proof is satisfactory only if we determine, in our discretion, that the proof provided establishes that you are entitled to benefits under This Plan.

C. When Proof of Claim Must Be Given

Written proof of a claim must be given to us not later than 90 days after the date of the loss, in the case of Accidental Death or Dismemberment Benefits.

D. Late Notice or Proof

If notice or proof is not given on time, the delay will not cause a claim to be denied or reduced as long as the notice or proof is given as soon as possible.

E. Time Limits on Starting Lawsuits

No lawsuit may be started to obtain benefits until 60 days after proof is given.

No lawsuit may be started more than 3 years after the time proof must be given.

No lawsuit may be brought regarding an individual coverage or eligibility for benefits until the individual has exhausted his administrative remedies under the Westinghouse Welfare Benefits Plan.

F. Medical Examinations

While a claim is pending, we, at our expense, have the right to have you examined by Doctors of our choice when and as often as we reasonably choose.

G. Autopsy

If Accidental Death or Dismemberment Benefits are claimed, we, at our expense, have, in the case of death, the right to have an autopsy made where it is not against the law.

Form G.23000-H3

WHEN BENEFITS END

A. If you retire, are laid off, or otherwise leave the Employer, all of your benefits will end on your last day worked. Your employment ends when you cease Active Work as an Employee. However, for the purpose of benefits, the Employer may deem your employment to continue for certain absences. See CONDITIONS UNDER WHICH YOUR ACTIVE WORK IS DEEMED TO CONTINUE.

B. If This Plan ends in whole or in part, your benefits which are affected will end.

The end of any type of benefits on account of a Covered Person will not affect a claim which is incurred before those benefits ended.

Form G.23000-F

CONDITIONS UNDER WHICH YOUR ACTIVE WORK IS DEEMED TO CONTINUE

If you are not Actively at Work as an Employee because of a situation set forth below, the Employer may deem you to be in Active Work as an Employee only for the purpose of continuing your employment and only for the periods specified below in order that certain of your benefits under This Plan may be continued.

All such benefits will be subject to prior cessation as set forth in WHEN BENEFITS END.

In any case, the benefits will end on:

1. the date the Employer notifies us that your benefits are not to be continued; or

2. the end of the last period for which the Employer has paid premiums to us for your benefits.

Your Sickness or Injury

With respect to all Personal Benefits, the period determined in accordance with the Employer's provision for an eligible Part-Time Employee, as defined herein.

Your Total Disability

If you become totally disabled, as determined by the Employer, your Basic Life Benefits may be continued in accordance with the Employer's provision for an eligible Part-Time Employee, as defined herein.

Form G.23000-L

NOTICES

This certificate is of value to you. It should be kept in a safe place. Your Beneficiary should know where the certificate is kept.

As soon as your benefits end, you should consult your Employer to find out what rights, if any, you may have to continue your protection.

Our Home Office is located at One Madison Avenue, New York, New York 10010.

Form G.23000-E

THIS IS THE END OF THE CERTIFICATE. THE FOLLOWING IS ADDITIONAL INFORMATION.

CLAIMS INFORMATION

Procedures for Presenting Claims for Life and Accidental Death or Dismemberment Benefits

All claim forms needed to file for benefits under the group insurance program can be obtained from the Employer who will also be ready to answer questions about the insurance benefits and to assist you or, if applicable, your beneficiary in filing claims.

Life and Accidental Death or Dismemberment Benefits Claims

Routine Questions

If there is any question about a claim payment, an explanation may be requested from the Employer who is usually able to provide the necessary information.

Claim Submission

In submitting claims for Life and Accidental Death or Dismemberment benefits ("Benefits"), the claimant must complete the appropriate claim form and submit the required proof as described in the certificate.

Claim forms must be submitted in accordance with the instructions on the claim form.

Initial Determination

After MetLife receives your claim for Benefits, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 90 days from the date we received your claim, unless MetLife notifies you within that period that there are special circumstances requiring an extension of time of up to 90 additional days.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification

will also include a description of the Plan review procedures and time limits, including a statement of your right to bring a civil action if your claim is denied after an appeal.

Appealing the Initial Determination

In the event a claim has been denied in whole or in part, you or, if applicable, your beneficiary can request a review of your claim by MetLife. This request for review should be sent in writing to Group Insurance Claims Review at the address of MetLife's office which processed the claim within 60 days after you or, if applicable, your beneficiary received notice of denial of the claim. When requesting a review, please state the reason you or, if applicable, your beneficiary believe the claim was improperly denied and submit in writing any written comments, documents, records or other information you or, if applicable, your beneficiary deem appropriate. Upon your written request, MetLife will provide you free of charge with copies of relevant documents, records and other information.

MetLife will re-evaluate all the information, will conduct a full and fair review of the claim, and you or, if applicable, your beneficiary will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date we received your request for review, unless MetLife notifies you within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied, references any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of your right to bring a civil action if your claim is denied after an appeal. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

YOUR EMPLOYEE BENEFIT PLAN

WESTINGHOUSE GOVERNMENT SERVICES GROUP

Personal Accident Insurance Coverage

Westinghouse Government Services Group
4350 Northern Pike
Monroville, PA 15146-2886

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

This certificate describes the benefits that are available to you. We urge you to read it carefully.

Benefits are provided through a group policy issued to Westinghouse Government Services Group by Metropolitan Life Insurance Company.

Westinghouse Government Services Group

MetLife®

Metropolitan Life Insurance Company
One Madison Avenue, New York, New York 10010-3690

Certifies that, under and subject to the terms and conditions of the Group Policy issued to the Employer, coverage is provided for each Employee as defined herein.

The date when an Employee is eligible for coverage is set forth in the form with the title Eligibility for Benefits.

The date when an Employee's Personal Benefits become effective is set forth in the form with the title Effective Dates of Personal Benefits.

The date when an Employee's Dependent Benefits become effective is set forth in the form with the title Effective Dates of Dependent Benefits.

The amounts of coverage are determined by the form with the title Schedule of Benefits.

Robert H. Benmosche
Chairman, President and Chief Executive Officer

Employer: **Westinghouse Government Services Company, LLC, and Westinghouse Government Environmental Services Company, LLC**

Group Policy No.: **96934-G**

Florida Residents: The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida.

For Maryland residents: The group insurance policy providing coverage under this certificate was issued

in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

If any prior certificate relating to the coverage set forth herein has been given to the Employee, such certificate is void.

Form G.23000-Cert.-1

For Texas Residents:

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call MetLife's toll-free telephone number for information or to make a complaint at

1-800-638-5433

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
Fax # 512 - 475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact MetLife first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR CERTIFICATE: This notice is for information only and does not become a part or condition of the attached document.

Para Residentes de Texas:

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de MetLife para informacion o para someter una queja al

1-800-638-5433

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas
P.O. Box 149104
Austin, TX 78714-9104
Fax # 512 - 475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con MetLife primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU CERTIFICADO: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

Arkansas residents please be advised of the following:

IMPORTANT NOTICE

IF YOU HAVE A QUESTION CONCERNING YOUR COVERAGE OR A CLAIM, FIRST CONTACT YOUR GROUP EMPLOYER OR GROUP ACCOUNT ADMINISTRATOR. IF, AFTER DOING SO, YOU STILL HAVE A CONCERN, YOU MAY CALL METLIFE'S TOLL-FREE TELEPHONE NUMBER:

1-800-638-5433

IF YOU ARE STILL CONCERNED AFTER CONTACTING BOTH YOUR GROUP EMPLOYER AND METLIFE, YOU SHOULD FEEL FREE TO CONTACT:

ARKANSAS INSURANCE DEPARTMENT
CONSUMER SERVICES DIVISION
1200 WEST THIRD
LITTLE ROCK, ARKANSAS 72201-1904

California residents please be advised of the following:

IMPORTANT NOTICE

TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT METLIFE AT:

METROPOLITAN LIFE INSURANCE COMPANY
1 MADISON AVENUE
NEW YORK, NY 10010
ATTN: CORPORATE CONSUMER RELATIONS DEPARTMENT
1-800-638-5433

IF, AFTER CONTACTING METLIFE REGARDING A COMPLAINT, YOU FEEL THAT A SATISFACTORY RESOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA INSURANCE DEPARTMENT AT:

CALIFORNIA DEPARTMENT OF INSURANCE
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013
1-800-927-4357 (within California)
1-213-897-8921 (outside California)

Georgia residents please be advised of the following:

IMPORTANT NOTICE

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

Utah residents please be advised of the following:

NOTICE TO POLICYHOLDERS

Insurance companies licensed to sell life insurance, health insurance, or annuities in the State of Utah are required by law to be members of an organization called the Utah Life and Health Insurance Guaranty Association ("ULHIGA"). If an insurance company that is licensed to sell insurance in Utah becomes insolvent (bankrupt), and is unable to pay claims to its policyholders, the law requires ULHIGA to pay some of the insurance company's claims. The purpose of this notice is to briefly describe some of the benefits and limitations provided to Utah insureds by ULHIGA.

PEOPLE ENTITLED TO COVERAGE

- You must be a Utah resident.
- You must have insurance coverage under an individual or group policy.

POLICIES COVERED

- ULHIGA provides coverage for certain life, health and annuity insurance policies.

EXCLUSIONS AND LIMITATIONS

Several kinds of insurance policies are specifically excluded from coverage. There are also a number of limitations to coverage. The following are not covered by ULHIGA:

- Coverage through an HMO.
- Coverage by insurance companies not licensed in Utah.
- Self-funded and self-insured coverage provided by an employer that is only administered by an insurance company.
- Policies protected by another state's Guaranty Association.
- Policies where the insurance company does not guarantee the benefits.
- Policies where the policyholder bears the risk under the policy.

- Re-insurance contracts.
- Annuity policies that are not issued to and owned by an individual, unless the annuity policy is issued to a pension benefit plan that is covered.
- Policies issued to pension benefit plans protected by the Federal Pension Benefit Guaranty Corporation.
- Policies issued to entities that are not members of the ULHIGA, including health plans, fraternal benefit societies, state pooling plans and mutual assessment companies.

LIMITS ON AMOUNT OF COVERAGE

Caps are placed on the amount ULHIGA will pay. These caps apply even if you are insured by more than one policy issued by the insolvent company. The maximum ULHIGA will pay is the amount of your coverage or $500,000 — whichever is lower. Other caps also apply:

- $100,000 in net cash surrender values.
- $500,000 in life insurance death benefits (including cash surrender values).
- $500,000 in health insurance benefits.
- $200,000 in annuity benefits — if the annuity is issued to and owned by an individual or the annuity is issued to a pension plan covering government employees.
- $5,000,000 in annuity benefits to the contract holder of annuities issued to pension plans covered by the law. (Other limitations apply).
- Interest rates on some policies may be adjusted downward.

DISCLAIMER

PLEASE READ CAREFULLY:

· **COVERAGE FROM ULHIGA MAY BE UNAVAILABLE UNDER THIS POLICY. OR, IF AVAILABLE, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS OR EXCLUSIONS. THE DESCRIPTION OF COVERAGES CONTAINED IN THIS DOCUMENT IS AN OVERVIEW. IT IS NOT A COMPLETE DESCRIPTION. YOU CANNOT RELY ON THIS DOCUMENT AS A DESCRIPTION OF COVERAGE. FOR A COMPLETE DESCRIPTION OF COVERAGE, CONSULT THE UTAH CODE, TITLE 31A, CHAPTER 28.**

· **COVERAGE IS CONDITIONED ON CONTINUED RESIDENCY IN THE STATE OF UTAH.**

· **THE PROTECTION THAT MAY BE PROVIDED BY ULHIGA IS NOT A SUBSTITUTE FOR CONSUMERS' CARE IN SELECTING AN INSURANCE COMPANY THAT IS WELL-MANAGED AND FINANCIALLY STABLE.**

· **INSURANCE COMPANIES AND INSURANCE AGENTS ARE REQUIRED BY LAW TO GIVE YOU THIS NOTICE. THE LAW DOES, HOWEVER, PROHIBIT THEM FROM USING THE EXISTENCE OF ULHIGA AS AN INDUCEMENT TO SELL YOU INSURANCE.**

· **THE ADDRESS OF ULHIGA, AND THE INSURANCE DEPARTMENT ARE PROVIDED BELOW.**

Utah Life and Health Insurance
Guaranty Association
955 E. Pioneer Rd.
Draper, Utah 84114

Utah Insurance Department
State Office Building, Room 3110
Salt Lake City, Utah 84114

-x-

Virginia residents please be advised of the following:

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact the insurance company issuing this insurance at the following address and telephone number:

Metropolitan Life Insurance Company
1 Madison Avenue
New York, New York 10010
Attn: Corporate Customer Relations Department

To phone in a claim related question, you may call Claims Customer Service at:

1-800-638-5433

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23209

1-800-552-7945 - In-state toll-free
1-804-786-3741 - Out-of-state

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Wisconsin residents please be advised of the following:

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

Metropolitan Life Insurance Company
Corporate Consumer Relations Department
1 Madison Avenue
New York, NY 10010
1-800-638-5433

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517 outside of Madison or 266-0103 in Madison.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS
(Also see SCHEDULE SUPPLEMENT)

The following Benefits are provided subject to the provisions below.

VOLUNTARY ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS	**AMOUNT**
Employee	Increments of $10,000 to a Maximum Benefit of $350,000

Dependents

One unit of Family Coverage equals the total of:

Spouse	$10,000
Each Dependent Child	$2,000

You may elect up to a maximum of 10 Units of Family Coverage.

INCREASES IN AMOUNTS OF VOLUNTARY ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS

Your earnings on the date you become covered under This Plan will determine your benefits on that date. Any increase in your annual pay as of September 1st will increase your benefits. The change will take place on the following January 1st provided you are Actively at Work on that date. If you are not Actively at Work on that date, the change in your benefits will take place when you return to Active Work.

WHEN YOU RETIRE

No benefits are provided under This Plan on or after the day you retire.

Form G.23000-B

SCHEDULE SUPPLEMENT

A. Statements Made by You Which Relate to Insurability

Any statement made by you will be deemed a representation and not a warranty.

No such statement made by you which relates to insurability will be used:

1. in contesting the validity of the benefits with respect to which such statement was made; or

2. to reduce the benefits;

unless the conditions listed in items (a) and (b) below have been met:

   a. The statement must be contained in a written application which has been signed by you.

   b. A copy of the application has been furnished to you or to your Beneficiary.

No such statement made by you will be used at all after such benefits have been in force prior to the contest for a period of two years during the lifetime of the person to whom the statement applies.

B. Assignment

The benefits with respect to the Accidental Death or Dismemberment Benefits for which you are covered on your own account under This Plan may be assigned as a gift. Any such assignment will transfer all right, title, interest and incidents of ownership, both present and future, in such benefits, including, but not limited to, the following:

1. The right to make any contributions required to keep the benefits in force under This Plan.

2. The right to change the Beneficiary.

3. The privilege of obtaining an individual policy of life insurance.

No assignment will be binding on us nor on the Employer unless the following conditions are met:

1. The assignment is in a form which is acceptable to us and to the Employer.

2. The assignment is accepted, in writing, by us and by the Employer.

3. The assignment is filed at our Home Office.

We assume no obligation as to the validity or the sufficiency of any assignment; neither does the Employer.

C. Additional Provisions

1. The benefits under This Plan do not at any time provide paid-up insurance, or loan or cash values.

2. No agent has the authority:

   a. to accept or to waive the required proof of a claim; nor

   b. to extend the time within which a proof must be given to us.

Form G.23000-B1

DEFINITIONS OF CERTAIN TERMS USED HEREIN

"Actively at Work" or **"Active Work"** means that you are performing all of the material duties of your job with the Employer where these duties are normally carried out. If you were Actively at Work on your last scheduled working day, you will be deemed Actively at Work:

1. on a scheduled non-working day;

2. provided you are not disabled.

"Casual Employee" means a person who is hired either:

1. for a predetermined limited period of time, usually not longer than two or three months; or.

2. for the purpose of completing a specific task that is anticipated not to exceed five months, and who has no expectation of continued employment beyond the completion of that task.

The determination of who is a Casual Employee shall be made on a uniform and nondiscriminatory basis.

Casual employees include summer students, interns, and co-op students who alternate periods of full-time employment with periods of full-time study.

"Covered Person" means an Employee or a Dependent on whose account benefits are in effect under This Plan.

"Dependent" means your spouse or your unmarried child except for:

1. a person who is in the military or like forces of any country or of any subdivision of a country;

2. a person who lives outside the United States or Canada;

3. a child who:

a. is 19 years of age or older and who is employed on a full-time basis; or

b. is 21 years of age or older and who is not a full-time student at an approved school, as determined by the Employer; or

c. is 25 years of age or older.

If a Dependent child is a Covered Person on the day before that child has reached the applicable age limit, that child will continue to be a Dependent after the age limit as long as:

a. that child is and remains unable to work in self-sustaining employment because of:

i. physical handicap; or

ii. mental retardation; and

b. that child is and remains chiefly dependent upon you for support; and

c. that child is and remains a Dependent, as defined, except for the age limit; and

d. you give us proof, when we ask for it, that the child is and remains so unable to work and dependent upon you since the age limit. We will not ask for proof more than once a year. The proof must be satisfactory to us; and

e. you make any payment which is required by the Employer.

Child includes:

a. a child who is supported solely by you and permanently living in the home of which you are the head; and

b. a child who is legally adopted or placed for adoption; and

c. a stepchild who lives in your home; and

d. a child for whom benefits must be provided by court order, that we have been notified of (as set forth in a divorce decree).

No person may be covered as a Dependent of more than one Employee.

"Dependent Benefits" mean the benefits which are provided on account of a Dependent under This Plan.

"Doctor" means a person who is legally licensed to practice medicine. A licensed practitioner will be considered a Doctor if:

1. there is a law which applies to This Plan and that law requires that any service performed by such a practitioner must be considered for benefits on the same basis as if the service were performed by a Doctor; and

2. the service performed by the practitioner is within the scope of his or her license.

"Employee" means a person who is employed and paid for services by the Employer on a Full-Time basis. Employee does not include Part-Time and Casual Employees and Employees in excluded units, as determined by the Employer.

An individual hired through a temporary agency, a contract, or any other arrangement, who is not coded as an employee on the employer's payroll records, is not an Employee. This rule applies even if a court or administrative agency determines that the individual is a "leased employee" under the Internal Revenue Code, or is an employee under common law or other legal standards.

"Employer" means Westinghouse Government Services Company, LLC, or Westinghouse Government Environmental Services Company, LLC, or any subsidiary or affiliate that, by action of its Board of Directors, and with the approval of the Board of Directors of Westinghouse, adopts the Plan and this Policy.

"Excluded Unit" means a group of Employees named by Westinghouse Government Services Group as not eligible to participate in the Plan.

"Full-Time" means a person who is regularly scheduled to work more than 80% of the established number of hours for a location, whether calculated on a daily, weekly, monthly or annual basis.

"Grandfathered Part-Time Employee" means a Part-Time Employee who has been continuously employed as such Part-Time Employee since December 31, 1990 and eligible for benefits since December 31, 1990.

"Hospital" means a facility which:

1. is legally licensed; and

2. provides a broad range of 24 hour a day medical and surgical services for sick and injured persons by, or under the supervision of, a staff of Doctors; and

3. provides 24 hour a day nursing care by, or under the direction of, a registered professional nurse (R.N.).

"Part-Time" means a person who is regularly scheduled to work 80% or less of the established number of hours for a location, whether calculated on a daily, weekly, monthly or annual basis.

"Personal Benefits" mean the benefits which are provided on account of an Employee under This Plan.

"Qualifying Events" means a change in your family status due to one or more of the following:

1. changes in Your legal marital status, such as by marriage, divorce, legal separation, death of spouse or annulment;

2. change in the number of Your dependents, such as by birth, adoption, placement for adoption or death of a dependent;

3. changes in the employment status of You, Your spouse or Your dependent child if it causes You, Your spouse or Your dependent child to gain or lose eligibility for insurance; and

4. changes in the work schedule of You, Your spouse or Your dependent child if it causes You, Your spouse or Your dependent child to gain or lose eligibility for insurance; and

5. Your dependent's ceasing to be a Dependent as defined under This Plan.

"This Plan" means the Group Policy which is issued by us to provide Personal Accident Insurance Coverage (also referred to as Voluntary Accidental Death or Dismemberment) under the Westinghouse Government Services Group Welfare Benefits Plan.

"We", **"us"** and **"our"** mean Metropolitan.

"You" and **"your"** mean the Employee who is a Covered Person for Personal Benefits. They do not include a Dependent of the Employee.

Form G.23000-A

ELIGIBILITY FOR BENEFITS

Personal Benefits Eligibility Date

Your Personal Benefits Eligibility Date is the later of:

1. January 1, 2004; and
2. the first day of the calendar month after the date you complete 30 days of continuous service as an Employee of the Employer.

Dependent Benefits Eligibility Date

Your Dependent Benefits Eligibility Date is the later of your Personal Benefits Eligibility Date and the date you first acquire a Dependent.

Form G.23000-C

EFFECTIVE DATES OF PERSONAL BENEFITS

APPLICABLE TO EMPLOYEES PARTICIPATING IN THE WESTINGHOUSE GOVERNMENT SERVICES GROUP WELFARE BENEFITS PLAN

A. Making a Request for Benefits

In order to become insured for Voluntary Accidental Death or Dismemberment Benefits under This Plan, you must contact the Westinghouse Benefits Center to enroll.

Requests to be covered for Personal benefits may only be made:

1. during the thirty-one day period following your Personal Benefits Eligibility Date in which case your Personal Benefits will become effective on your Personal Benefits Eligibility Date; or

2. during the thirty-two through sixty day period following your Personal Benefits Eligibility Date in which case your Personal Benefits will become effective on the first day of the month following your request.

3. during any annual enrollment period, as designated by the Employer and reported to you following your Personal Benefits Eligibility Date in which case your Personal Benefits will become effective the January 1st following the date of such request.

Requests for changes in Personal Benefits may only be made during the annual enrollment period, as designated by the Employer and reported to you. If you make a request to change the level of your Personal Benefits during an annual enrollment period, your Personal Benefits will become effective on the January 1st following the annual enrollment period, subject to the Active Work Requirements.

B. Active Work Requirement

You must be Actively at Work as an Employee in order for your Personal Benefits to become effective. If you are not Actively at Work as an Employee on the date when your Personal Benefits would otherwise become effective, your Personal Benefits will become effective on the date of your return to Active Work as an Employee.

C. Reinstatement of Benefits

If your Personal Benefits end because you do not make a required contribution to their cost, you may make a request to reinstate them, subject to the foregoing provisions.

Form G.23000-D1

EFFECTIVE DATES OF DEPENDENT BENEFITS

A. Enrollment

In order to enroll for Dependent Benefits, you must contact the Westinghouse Benefits Center.

B. Making a Request for Benefits

A timely request is one that is made on or prior to the date thirty-one days after your Dependent Benefits Eligibility Date. If you are not Actively at Work as an Employee on your Dependent Benefits Eligibility Date, a request will be timely if it is made on or prior to the date thirty-one days after the date you return to Active Work as an Employee.

Requests for increases or decreases in your Dependent Benefits may be made at any time. The change will become effective the first of the month following the date of your request.

Requests to be covered for Dependent Benefits may only be made:

1. during the thirty-one day period following your Dependent Benefits Eligibility Date; or

2. within sixty days of a Qualifying Event; or

3. during an annual enrollment period as designated by the Employer and reported to you, following your Dependent Benefits Eligibility Date.

If you make a request to be covered for Dependent Benefits within thirty-one days of your Dependent Benefits Eligibility Date, your Dependent Benefits will become effective, on the later of:

a. your Dependent Benefits Eligibility Date; and

b. the effective date of your Personal Benefits.

If you make a request to be covered for Dependent Benefits within sixty days, but after thirty-one days, following your Personal Benefits

Eligibility Date, your Personal Benefits will become effective on the first day of the month following your request.

If you make a request to be covered for Dependent Benefits or a request for an increase in Dependent Benefits during an enrollment period, your Dependent Benefits or the increase in the Dependent Benefits will become effective on the first day of the calendar year following the date of such request.

C. Active Work Requirement

You must be Actively at Work as an Employee in order for your Dependent Benefits to become effective. If you are not Actively at Work as an Employee on the date when your Dependent Benefits would otherwise become effective, your Dependent Benefits will become effective on the date of your return to Active Work as an Employee.

D. Reinstatement of Benefits

If your Dependent Benefits end because you do not make a required contribution to their cost, you may make a request to reinstate them, subject to the foregoing provisions. You may also request reinstatement of Dependent Benefits if your Dependent, after age 19 but prior to age 21, again becomes eligible for benefits after being ineligible.

E. New Dependents

Dependent Benefits with respect to a person who becomes your Dependent while you are covered for Dependent Benefits will be effective on the date such person becomes your Dependent, subject to all provisions herein.

Form G.23000-D2

ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS

A. Coverage

We will pay Accidental Death or Dismemberment Benefits for a Covered Loss shown in Section C if:

1. you are injured in an accident which occurs while you are covered for Accidental Death or Dismemberment Benefits; or

2. a Dependent is injured in an accident which occurs while Accidental Death or Dismemberment Benefits are in effect for that Dependent;

and if, in either case:

a. that accident is the sole cause of the injury; and

b. that injury is the sole cause of that Covered Loss; and

c. that Covered Loss occurs within 24 months of the date of that accident.

B. Maximum Benefit for All Covered Losses in Each Accident

For all Covered Losses caused by all injuries which:

1. you sustain in one accident; or

2. a Dependent sustains in one accident;

not more than the Full Amount will be paid.

Full Amount means the amount of Accidental Death or Dismemberment Benefits:

1. for which you are covered on the date of your accident; or

2. that is in effect for that Dependent on the date of that Dependent's accident.

C. Table of Covered Losses and Benefit Amounts

Covered Losses (Subject to Exclusions)	**Benefit Amounts**
Life	Full Amount
A hand	One-half of the Full Amount
A foot	One-half of the Full Amount
Sight of an eye	One-half of the Full Amount
Any combination of a hand, a foot or sight of an eye	Full Amount
Paralysis of one limb	One-half of the Full Amount
Quadriplegia	Full Amount
Paraplegia	Full Amount
Hemiplegia	Full Amount

Loss of sight of an eye means that the eye is entirely blind and that no sight can be restored in that eye.

Loss of a hand means that all of the hand is cut off at or above the wrist.

Loss of a foot means that all of the foot is cut off at or above the ankle.

Quadriplegia means total paralysis of both upper and lower limbs.

Paraplegia means total paralysis of both lower limbs.

Hemiplegia means total paralysis of upper and lower limbs on one side of the body.

Paralysis means loss of use, without severance, of a limb. Paralysis must be determined by competent medical authority to be permanent, complete and irreversible. Paralysis must last 12 consecutive months after the accident before a benefit will be paid.

D. Exclusions

We will not pay for any Covered Loss shown in Section C if it in any way results from, or is caused or contributed to by:

1. physical or mental illness, diagnosis of or treatment for the illness; or

2. an infection, unless it is caused by an external wound that can be seen and which was sustained in an accident; or

3. suicide or attempted suicide; or

4. injuring oneself on purpose; or

5. the use of any drug or medicine voluntarily taken, unless used on the advice of a Doctor; or

6. a war, or a warlike action in time of peace, including terrorist acts; or

7. committing or trying to commit a felony or other serious crime or an assault; or

8. any poison or gas, voluntarily taken, administered or absorbed; or

E. Payment of Benefits

The Accidental Death or Dismemberment Benefits for a Covered Loss will be paid when we receive notice and satisfactory proof of that loss.

Accidental Death or Dismemberment Benefits will be paid:

1. to your Beneficiary for the loss of your life; and

2. to you for any other Covered Loss sustained by you; and

3. to you for the loss of life of a Dependent, if you survive the Dependent; the benefits will be paid to your estate if:

   a. that Dependent dies at the same time your death occurs; or

   b. that Dependent dies within 24 hours of your death;

   in any other instance the benefits will be paid to that Dependent's estate; and

4. to you for any other Covered Loss sustained by a Dependent, if you survive that Dependent; otherwise the benefits will be paid to that Dependent.

F. Optional Types of Payment

Payment of any amount of Accidental Death or Dismemberment Benefits for loss of life may be made in installments. Details on the payment options may be obtained from the Employer.

Form G.23000-4L

BENEFICIARY

A. Your Beneficiary

The "Beneficiary" is the person or persons you choose to receive any benefit payable because of your death.

You make your choice in writing on a form approved by us. This form must be filed with the records for This Plan.

Unless you have assigned your benefits under this Plan, you may change the Beneficiary at any time by filing a new form with the Employer. You do not need the consent of the Beneficiary to make a change. When the Employer receives a form changing the Beneficiary, the change will take effect as of the date you signed it.

The change of Beneficiary will take effect even if you are not alive when it is received.

A change of Beneficiary will not apply to any payment made by us prior to the date the form was received by the Employer.

B. More Than One Beneficiary

If, when you die, more than one person is your Beneficiary, they will share in the benefits equally, unless you have chosen otherwise.

C. Death of a Beneficiary

A person's rights as a Beneficiary end if:

1. that person dies before your death occurs; or

2. that person dies at the same time your death occurs; or

3. that person dies within 24 hours of your death.

The share for that person will be divided among the surviving persons you have named as Beneficiary, unless you have chosen otherwise.

D. No Beneficiary at Your Death

If there is no Beneficiary at your death for any amount of benefits payable because of your death, that amount will be paid to one or more of the following persons who are related to you and who survive you:

a. surviving spouse;

b. if there is no surviving spouse, to the employee's surviving children in equal shares;

c. if there are no surviving children, to the surviving parents of the employee in equal shares;

d. if there are no surviving parents, to the employee's surviving brothers or sisters in equal shares; and

e. if there are no surviving brothers or sisters, to your estate.

If there is no surviving relative in any class, that amount will be payable to your estate. Any payment will discharge our liability for the amount so paid.

Form G.23000-G

CLAIM PROCEDURE FOR ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS

A. When Notice of Claim Must be Given

Written notice of a claim must be given to us for Accidental Death or Dismemberment Benefits within 20 days after the date of the accident which caused the loss.

B. Claim Forms

When we receive written notice of a claim, we may furnish printed forms for filing proof of the claim. If we do not furnish printed forms within 15 days after you give us notice, you must furnish your own form of proof in writing.

Proof must describe the event, the nature and the extent of the cause for which a claim is made; it must be satisfactory to us.

Proof is satisfactory only if we determine, in our discretion, that the proof provided establishes that you are entitled to benefits under This Plan.

C. When Proof of Claim Must Be Given

Written proof of a claim must be given to us not later than 90 days after the date of the loss, in the case of Accidental Death or Dismemberment Benefits.

D. Late Notice or Proof

If notice or proof is not given on time, the delay will not cause a claim to be denied or reduced as long as the notice or proof is given as soon as possible.

E. Time Limits on Starting Lawsuits

No lawsuit may be started to obtain benefits until 60 days after proof is given.

No lawsuit may be started more than 3 years after the time proof must be given.

No lawsuit may be brought regarding an individual coverage or eligibility for benefits until the individual has exhausted his administrative remedies under the Westinghouse Welfare Benefits Plan.

F. Medical Examinations

While a claim is pending, we, at our expense, have the right to have you examined by Doctors of our choice when and as often as we reasonably choose.

G. Autopsy

If Accidental Death or Dismemberment Benefits are claimed, we, at our expense, have, in the case of death, the right to have an autopsy made where it is not against the law.

Form G.23000-H3

WHEN COVERAGE ENDS

A. All of your benefits will end on your last day worked. Your employment ends when you cease Active Work as an Employee. However, for the purpose of benefits, the Employer may deem your employment to continue for certain absences. See CONDITIONS UNDER WHICH YOUR ACTIVE WORK IS DEEMED TO CONTINUE.

B. If This Plan ends in whole or in part, your benefits which are affected will end.

C. Your Dependent Benefits will end on the earlier of:

1. the date that the Dependent ceases to be your Dependent; or

2. the date of your death.

D. If a Covered Person does not make a payment which is required by the Employer to the cost of any benefits, those benefits will end; they will end on the last day of the period for which you last made the required contribution.

The end of any type of benefits on account of a Covered Person will not affect a claim which is incurred before those benefits ended.

Form G.23000-F

CONDITIONS UNDER WHICH YOUR ACTIVE WORK IS DEEMED TO CONTINUE

If you are not Actively at Work as an Employee because of a situation set forth below, the Employer may deem you to be in Active Work as an Employee only for the purpose of continuing your employment and only for the periods specified below in order that certain of your benefits under This Plan may be continued.

All such benefits will be subject to prior cessation as set forth in WHEN COVERAGE ENDS.

In any case, the benefits will end on:

1. the date the Employer notifies us that your benefits are not to be continued; or

2. the end of the last period for which the Employer has paid premiums to us for your benefits.

Your Sickness or Injury, Your Leave of Absence, Your Lay Off, or Permanent Job Separation

With respect to all Personal Benefits and all Dependent Benefits, the period determined in accordance with the Employer's general practice for an Employee in your job class

However, in the event the leave qualifies under the Family and Medical Leave Act of 1993 (FMLA), the period cannot be longer than 12 weeks in any 12 month period following the date the leave of absence begins.

Form G.23000-L

NOTICES

As soon as your benefits end, you should consult your Employer to find out what rights, if any, you may have to continue your protection.

Our Home Office is located at One Madison Avenue, New York, New York 10010.

Form G.23000-E

THIS IS THE END OF THE CERTIFICATE. THE FOLLOWING IS ADDITIONAL INFORMATION.

CLAIMS INFORMATION

Procedures for Presenting Claims for Accidental Death or Dismemberment Benefits

All claim forms needed to file for benefits under the group insurance program can be obtained from the Employer who will also be ready to answer questions about the insurance benefits and to assist you or, if applicable, your beneficiary in filing claims.

Accidental Death or Dismemberment Benefits Claims

Routine Questions

If there is any question about a claim payment, an explanation may be requested from the Employer who is usually able to provide the necessary information.

Claim Submission

In submitting claims for Accidental Death or Dismemberment benefits ("Benefits"), the claimant must complete the appropriate claim form and submit the required proof as described in the certificate.

Claim forms must be submitted in accordance with the instructions on the claim form.

Initial Determination

After MetLife receives your claim for Benefits, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 90 days from the date we received your claim, unless MetLife notifies you within that period that there are special circumstances requiring an extension of time of up to 90 additional days.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient

information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Plan review procedures and time limits, including a statement of your right to bring a civil action if your claim is denied after an appeal.

Appealing the Initial Determination

In the event a claim has been denied in whole or in part, you or, if applicable, your beneficiary can request a review of your claim by MetLife. This request for review should be sent in writing to Group Insurance Claims Review at the address of MetLife's office which processed the claim within 60 days after you or, if applicable, your beneficiary received notice of denial of the claim. When requesting a review, please state the reason you or, if applicable, your beneficiary believe the claim was improperly denied and submit in writing any written comments, documents, records or other information you or, if applicable, your beneficiary deem appropriate. Upon your written request, MetLife will provide you free of charge with copies of relevant documents, records and other information.

MetLife will re-evaluate all the information, will conduct a full and fair review of the claim, and you or, if applicable, your beneficiary will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date we received your request for review, unless MetLife notifies you within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied, references any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of your right to bring a civil action if your claim is denied after an appeal. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

WESTINGHOUSE GOVERNMENT SERVICES GROUP

Additional/Supplemental Life Insurance Coverage

Westinghouse Government Services Group LLC
4350 Northern Pike, Room 217C
Monroeville, PA 15146-2886

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

This certificate describes the benefits that are available to you. We urge you to read it carefully.

Benefits are provided through a group policy issued to Westinghouse Government Services Group LLC by Metropolitan Life Insurance Company.

Westinghouse Government Services Group LLC

MetLife

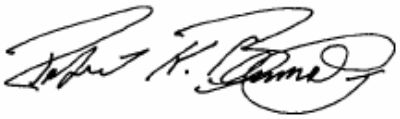
Metropolitan Life Insurance Company
One Madison Avenue, New York, New York 10010-3690

Certifies that, under and subject to the terms and conditions of the Group Policy issued to the Employer, coverage is provided for each Employee as defined herein.

The date when an Employee is eligible for coverage is set forth in the form with the title Eligibility for Benefits.

The date when an Employee's Personal Benefits become effective is set forth in the form with the title Effective Dates of Personal Benefits.

The amounts of coverage are determined by the form with the title Schedule of Benefits.



Robert H. Benmosche
Chairman, President and Chief Executive Officer

Employer: Westinghouse Government Services Group LLC

Group Policy No.: 96934G

For Maryland residents: The group life insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

If any prior certificate relating to the coverage set forth herein has been given to the Employee, such certificate is void.

Form G.23000-Cert.-1

Arkansas residents please be advised of the following:

IMPORTANT NOTICE

IF YOU HAVE A QUESTION CONCERNING YOUR COVERAGE OR A CLAIM, FIRST CONTACT YOUR GROUP EMPLOYER OR GROUP ACCOUNT ADMINISTRATOR. IF, AFTER DOING SO, YOU STILL HAVE A CONCERN, YOU MAY CALL METLIFE'S TOLL-FREE TELEPHONE NUMBER:

1-800-275-4638

IF YOU ARE STILL CONCERNED AFTER CONTACTING BOTH YOUR GROUP EMPLOYER AND METLIFE, YOU SHOULD FEEL FREE TO CONTACT:

ARKANSAS INSURANCE DEPARTMENT
CONSUMER SERVICES DIVISION
400 UNIVERSITY TOWER BUILDING
LITTLE ROCK, ARKANSAS 72204

California residents please be advised of the following:

IMPORTANT NOTICE

TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT METLIFE AT:

METROPOLITAN LIFE INSURANCE COMPANY
1 MADISON AVENUE
NEW YORK, NY 10010
ATTN: CORPORATE CONSUMER RELATIONS DEPARTMENT
1-800-275-4638

IF, AFTER CONTACTING METLIFE REGARDING A COMPLAINT, YOU FEEL THAT A SATISFACTORY RESOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA INSURANCE DEPARTMENT AT:

CALIFORNIA DEPARTMENT OF INSURANCE
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013
1-800-927-4357 (within California)
1-213-897-8921 (outside California)

For Texas Residents:

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call MetLife's toll-free telephone number for information or to make a complaint at

1-800-638-5433

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
Fax # 512 - 475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact MetLife first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

Para Residentes de Texas:

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de MetLife para informacion o para someter una queja al

1-800-638-5433

Puede comunicarse con el Departmento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departmento de Seguros de Texas
P.O. Box 149104
Austin, TX 78714-9104
Fax # 512 - 475-1771

DISPUTES SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con MetLife primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS
(Also see SCHEDULE SUPPLEMENT)

The following Benefits are provided subject to the provisions below.

BENEFITS (EMPLOYEE ONLY)	AMOUNT
ADDITIONAL/SUPPLEMENTAL LIFE	An amount equal to the amount of your additional/supplemental life benefits in effect on December 31, 1991, as determined by your Employer.

INCREASES AND DECREASES IN AMOUNTS OF ADDITIONAL/SUPPLEMENTAL LIFE BENEFITS

No increases in coverage amounts are allowed. Any increase in your annual earnings will not increase your benefit amount. However, your benefit is subject to reduction at specified ages or at retirement as described herein.

IF YOU STOP COVERAGE

If you elect to stop participating in the Plan or your coverage stops for any reason, you will not be able to re-enroll at any time in the future.

WHEN YOU RETIRE

If you retire, under the Westinghouse Government Services Group Pension Plan or the pension plan of a company at least 50% owned by Westinghouse, the following retirement provision applies to you. This provision does not apply to you if you have a right to a vested pension under that plan and you leave Westinghouse before becoming eligible for retirement.

If you retire before age 62, you must pay to continue your Additional/Supplemental Life Benefits to age 62. Your benefits will continue in full until the first day of the month following your 62nd birthday. At that time, your contributions stop and your benefits end unless you have at least 10 years of eligibility service, as determined by the Employer, in which case your benefits continue, but reduce. Such reduction will become effective on the first days of the month following your 62nd birthday. Your benefit will reduce by 5% of the amount of benefits in effect on the day before your 62nd birthday. The dollar amount determined by the initial 5% reduction will be the same dollar amount by which your benefits will continue to reduce on the first day of each month following the initial reduction. Such reduction will continue until your benefit reduces to one-third of the amount in effect on December 31, 1991.

If you retire on or after age 62, and you have 10 years of eligibility service as determined by the Employer, the amount of your Additional/Supplemental Life Benefit will reduce by 5% on your retirement date. The dollar amount determined by the initial 5% reduction will be the same dollar amount by which your benefits will continue to reduce on the first day of each month following the initial reduction. Such reduction will continue until your benefit reduces to one-third of the amount in effect on December 31, 1991.

If you are rehired after your retirement, by the Employer or any company at least 50% owned by the Employer, your Additional/Supplemental Life Benefits under This Plan will terminate and you will never be given the opportunity to re-enroll in Additional/Supplemental Life Insurance Coverage in the future. You will be covered under the plan, if any, in effect for your new employment. If you again become eligible to retire under the terms of the plan, coverage in retirement will be provided in accordance with the terms and provisions of the plan in effect at the time of your most current retirement.

Form G.23000-B

SCHEDULE SUPPLEMENT

A. Statements Made by You Which Relate to Insurability

Any statement made by you will be deemed a representation and not a warranty.

No such statement made by you which relates to insurability will be used:

1. in contesting the validity of the benefits with respect to which such statement was made; or

2. to reduce the benefits;

unless the conditions listed in items (a) and (b) below have been met:

a. The statement must be contained in a written application which has been signed by you.

b. A copy of the application has been furnished to you or to your Beneficiary.

No such statement made by you will be used at all after such benefits have been in force prior to the contest for a period of two years during the lifetime of the person to whom the statement applies.

B. Assignment

The benefits with respect to the Life Benefits (On Your Own Account) under This Plan may be assigned as a gift. Any such assignment will transfer all right, title, interest and incidents of ownership, both present and future, in such benefits, including, but not limited to, the following:

1. The right to make any contributions required to keep the benefits in force under This Plan.
2. The privilege of obtaining an individual policy of life insurance.
3. The right to change the Beneficiary.

No assignment will be binding on us nor on the Employer unless the following conditions are met:

1. The assignment is in a form which is acceptable to us and to the Employer.
2. The assignment is accepted, in writing, by us and by the Employer.
3. The assignment is filed at our Home Office.

We assume no obligation as to the validity or the sufficiency of any assignment; neither does the Employer.

tr. Additional Provisions

1. The benefits under This Plan do not at any time provide paid-up insurance, or loan or cash values.
2. No agent has the authority:
   a. to accept or to waive the required notice or proof of a claim; nor
   b. to extend the time within which a notice or a proof must be given to us.

Form G.23000-B1

DEFINITIONS OF CERTAIN TERMS USED HEREIN

"Covered Person" means an Employee on whose account benefits are in effect under This Plan.

"Employee" means a person who is employed and paid for services by the Employer on a Full-Time basis, and who was enrolled in the flexible benefits plan on January 1, 1991 and has maintained continuous coverage since December 31, 1991.

An individual hired through a temporary agency, a contract, or any other arrangement, who is not coded as an employee on the employer's payroll records, is not an Employee. This rule applies even if a court or administrative agency determines that the individual is a "leased employee" under the Internal Revenue Code, or is an employee under common law or other legal standards.

"Employer" means Westinghouse Government Services Group LLC, or any subsidiary or affiliate that, by action of its Board of Directors, and with the approval of the Board of Directors of Westinghouse, adopts the Plan and This Plan.

"Full-Time" means an Employee who is (a) regularly scheduled to work more than 80% of the established number of hours for a location, whether calculated on a daily, weekly, monthly or annual basis; (b) a Grandfathered Part-Time Employee.

"Grandfathered Part-Time Employee" means a Part-Time Employee who has been continuously employed as such Part-Time Employee since December 31, 1990, and eligible for benefits since December 31, 1990.

"Lay Off" means that employment ends:

1. through no fault of the Employee for lack of work for reasons related to the business; and

2. the Employee elects lay-off in lieu of Permanent Job Separation.

"Permanent Job Separation" means when employment ends through no fault of the Employee for lack of work for reasons related to the business, and the Employer has no reasonable expectation of re-employment, as determined by the Employer.

"Personal Benefits" mean the benefits which are provided on account of an Employee under This Plan.

"Successor Employer" means an employer that buys or takes control of the Westinghouse business that employs you.

"This Plan" means the Group Policy which is issued by us to provide Personal Benefits.

"We", "us" and "our" mean Metropolitan.

"You" and "your" mean the Employee who is a Covered Person for Personal Benefits.

Form G.23000-A

ELIGIBILITY FOR BENEFITS

Personal Benefits Eligibility Date

Your Personal Benefits Eligibility Date is January 1, 2000 if:

1. you were an Employee, as defined herein, on January 1, 2000;

2. you were enrolled in the plan as of January 1, 1991, and have maintained continuous coverage since December 31, 1991.

Form G.23000-C

EFFECTIVE DATES OF PERSONAL BENEFITS

Your Personal Benefits will become effective on your Personal Benefits Eligibility Date.

Form G.23000-D1

LIFE BENEFITS
(On Your Own Account)

A. Coverage

If you die while you are covered for Life Benefits, we will pay to the Beneficiary the amount of Life Benefits that is in effect on your life on the date of your death.

B. Optional Types of Payment

Payment of any amount of Life Benefits may be made in installments. Details on the payment options may be obtained from the Employer.

Form G.23000-1

RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON YOUR OWN LIFE

A. Application

We will issue a personal policy of life insurance without disability or accidental death benefits to you if you apply for it in writing during the Application Period. The Application Period is the 31 day period after:

1. the date your Life Benefits end because your employment ends or because you are no longer in a class which remains eligible for Life Benefits; or

2. the date your Life Benefits end because This Plan ends, but only if your Life Benefits under This Plan have been in effect for at least 5 years; or

3. the date This Plan is changed to end the Life Benefits for your class, but only if your Life Benefits under This Plan have been in effect for at least 5 years.

4. the date your Life Benefits end because of your employment with a Successor Employer.

Proof that you are insurable is not required by us.

B. Conditions

The personal policy will be issued to you subject to these conditions:

1. it will be on one of the forms then usually issued by us, except term insurance; and

2. it will not take effect until after the Application Period ends; and

3. the premium for the policy will be based on:

    a. the class of risk to which you belong; and

b. your age on the effective date of the policy; and

c. the form and amount of the policy; and

4. if item A(1) applies to you, the amount of the policy will not be more than the amount of your Life Benefits on the date the Life Benefits end; and

5. if item A(2) or item A(3) applies to you, the amount of the policy will not be more than the lesser of

   a. the amount of your Life Benefits on the date the Life Benefits end, less any amount of life insurance for which you may be eligible under any group policy which takes effect within 31 days after your Life Benefits end; and

   b. $2,000.

C. If You Die During the Application Period

If you die during the Application Period, we will pay a death benefit to the Beneficiary. The amount of the death benefit will be the highest amount of life insurance pursuant to item B(4) or B(5) for which a personal policy could have been issued. This death benefit will be paid even if you did not apply for a personal policy.

Form G.23000-1A

BENEFICIARY

A. Your Beneficiary

The "Beneficiary' is the person or persons you choose to receive any benefit payable because of your death.

You make your choice in writing on a form approved by us. This form must be filed with the records for This Plan.

Unless you have assigned your benefits under This Plan, you may change the Beneficiary at any time by filing a new form with the Employer. You do not need the consent of the Beneficiary to make a change. When the Employer receives a form changing the Beneficiary, the change will take effect as of the date you signed it. The change of Beneficiary will take effect even if you are not alive when it is received.

A change of Beneficiary will not apply to any payment made by us prior to the date the form was received by the Employer.

Your choice of a Beneficiary for a personal policy issued under RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON YOUR OWN LIFE will be effective for This Plan.

B. More Than One Beneficiary

If, when you die, more than one person is your Beneficiary, they will share in the benefits equally, unless you have chosen otherwise.

C. Death of a Beneficiary

A person's rights as a Beneficiary end if:

1. that person dies before your death occurs; or
2. that person dies at the same time your death occurs; or
3. that person dies within 24 hours of your death.

The share for that person will be divided among the surviving persons you have named as Beneficiary, unless you have chosen otherwise.

D. No Beneficiary at Your Death

If there is no Beneficiary at your death for any amount of benefits payable because of your death, that amount will be paid to one or more of the following persons who are related to you and who survive you:

a. surviving spouse;

b. if there is no surviving spouse, to the employee's surviving children in equal shares;

c. if there are no surviving children, to the surviving parents of the employee in equal shares;

d. if there are no surviving parents, to the employee's surviving brothers or sisters in equal shares; and

e. if there are no surviving brothers or sisters to your estate.

If there is no surviving relative in any class, that amount will be payable to your estate.

Any payment will discharge our liability for the amount so paid.

Form G.23000-G

WHEN BENEFITS END

A. All of your benefits will end on your last day worked. However, for the purpose of benefits, the Employer may deem your employment to continue for certain absences. See CONDITIONS UNDER WHICH YOUR ACTIVE WORK IS DEEMED TO CONTINUE.

B. If This Plan ends in whole or in part, your benefits which are affected will end.

C. If a Covered Person does not make a payment which is required by the Employer to the cost of any benefits, those benefits will end; they will end on the last day of the period for which a payment required by the Employer was made.

The end of any type of benefits on account of a Covered Person will not affect a claim which is incurred before those benefits ended.
Form G.23000-F

CONDITIONS UNDER WHICH YOUR ACTIVE WORK IS DEEMED TO CONTINUE

If you are not Actively at Work as an Employee because of a situation set forth below, the Employer may deem you to be in Active Work as an Employee only for the purpose of continuing your employment and only for the periods specified below in order that certain of your benefits under This Plan may be continued.

All such benefits will be subject to prior cessation as set forth in WHEN BENEFITS END.

In any case, the benefits will end on:

1. the date the Employer notifies us that your benefits are not to be continued; or
2. the end of the last period for which the Employer has paid premiums to us for your benefits.

Your Sickness or Injury, Your Leave of Absence, Your Lay Off or Permanent Job Separation

With respect to all Personal Benefits, the period determined in accordance with the Employers general practices for an Employee in your job class.

Your Total Disability

If you become totally disabled, as determined by the Employer, the period determined in accordance with the Employer's provision for an eligible Employee, as defined herein.

Your Retirement

With respect to all Personal Benefits on and after the date of your retirement, for the period determined in accordance with the Employer's general practices for an Employee in your job class.

Form G.23000-1-

NOTICES

This certificate is of value to you. It should be kept in a safe place. Your Beneficiary should know where the certificate is kept.

As soon as your benefits end, you should consult your Employer to find out what rights, if any, you may have to continue your protection.

Our Home Office is located at One Madison Avenue, New York, New York 10010.

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ERISA INFORMATION

CLAIMS INFORMATION

Procedures for Presenting Claims for Benefits

All claim forms needed to file for benefits under the group insurance program can be obtained from your employer who will also be ready to answer questions about the insurance benefits and to assist you or, if applicable, your beneficiary in filing claims. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

The completed claim form should be returned to your Employer who will certify that you are insured under the Plan and will then forward the claim form to Metropolitan.

When the claim has been processed, you or, if applicable, your beneficiary will be notified of the benefits paid. If any benefits have been denied, you or, if applicable, your beneficiary will receive a written explanation.

Routine Questions

If there is any question about a claim payment, an explanation may be requested from your Employer who is usually able to provide the necessary information.

Requesting a Review of Claims Denied In Whole or In Part

In the event a claim has been denied in whole or in part, you or, if applicable, your beneficiary can request a review of your claim by Metropolitan. This request for review should be sent to Group Insurance Claims Review at the address of Metropolitan's office which processed the claim within 60 days after you or, if applicable, your beneficiary received notice of denial of the claim. When requesting a review, please state the reason you or, if applicable, your beneficiary believe the claim was improperly denied and submit any data, questions or comments you or, if applicable, your beneficiary deems appropriate.

Metropolitan will re-evaluate all the information and you or, if applicable, your beneficiary will be informed of the decision in a timely manner.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Appendix H – The Hartford Life and Accident Company Disability Insurance Booklets

- **Accident & Sickness Benefit Coverage (A&S)**

- **Long-Term Disability Benefit Coverage**

Note: CNA is now The Hartford and the certificates of insurance, which now say CNA, will be changed in the future to reflect The Hartford.

CNA Group Life Assurance Company

CNA Plaza
Chicago, Illinois 60685

A Stock Company

Having issued Group Policy No. SR-83115809

to

Westinghouse Government Services Company, LLC

(herein called the Employer)

CERTIFICATE OF INSURANCE

CERTIFIES that *You* are insured provided that *You* qualify under the *ELIGIBILITY* provision, become insured and remain insured in accordance with the terms of the Policy. *Your* insurance is subject to all the definitions, limitations and conditions of the Policy. It takes effect on the effective date indicated in the *EFFECTIVE DATE* provision. This certificate, however, is not the Policy. It is merely evidence of insurance provided under the Policy. The Policy can be amended by mutual consent between the Employer and *Us*.

This certificate replaces and cancels any other certificate previously issued to *You* under the Policy.
CDI-1AA

Signed for the CNA Group Life Assurance Company

Chairman of the Board

Group Short Term Disability Certificate

NON-PARTICIPATING

SBDI-C

TABLE OF CONTENTS

PROVISION ***PAGE***

Note: All terms in *italics* are listed and defined in the Definitions section or within the certificate itself.
CDI-3AA

SCHEDULE OF BENEFITS

Effective as of: January 1, 2003

Employer: Westinghouse Government Services Company, LLC or any subsidiary or affiliate that, by action of the Board of Directors, and with the approval of the Board of Directors of Westinghouse, has adopted or shall adopt the Westinghouse Welfare Benefits Plan.

Policy Number: SR-83115809

Policy Effective Date: January 1, 2003

Eligibility: All full-time hourly employees and those salaried AWSE employees at the Curtis Wright location working in the United States of America who are *Actively at Work* for the Employer and who have completed the waiting period required by the Employer as set forth in the Waiting Period section below.

A full-time employee is one who regularly works a minimum of 32.5 hours per week for the Employer. Independent contractors, part-time, seasonal, temporary and leased employees are not eligible.

Waiting Period: For employees in an eligible group on or before the Policy Effective Date who have not completed 30 days of continuous active employment: the 1st of the month after 30 days of continuous active full-time employment.

For employees entering an eligible group after the Policy Effective Date: the 1st of the month after 30 Days of continuous active, full-time employment.

Elimination Period: 7 Days – *Injury*

7 Days – *Sickness*

0 days for Inpatient *Hospital* Confinement or surgery in an out-patient surgical facility

STD Weekly Benefit:

Hourly Rate	Weekly Benefit
Less than $6.50	$150
$6.50 to $7.00	$162
$7.00 to $7.50	$175
$7.50 to $8.00	$186
$8.00 to $8.50	$198
$8.50 to $9.00	$210
$9.00 to $9.50	$222
$9.50 to $10.00	$234
$10.00 to $11.00	$252
$11.00 to $12.00	$276
$12.00 to $13.00	$300
$13.00 to $14.00	$324
$14.00 to $15.00	$348
$15.00 to $16.00	$372
Over $16.00	$396

	Subject to reduction by deductible sources of income or *Disability Earnings*.
Employer Contribution:	100% of premium
Maximum Period Payable:	26 weeks or until benefits become payable under the long term disability plan, whichever first occurs.

OTHER FEATURES

The following other features are included:

- Work Incentive Benefit
- Recurrent Disability
- FMLA Coverage Extension
- Continuity of Coverage

THIS SCHEDULE OF BENEFITS CANCELS AND REPLACES ALL OTHER SCHEDULES PREVIOUSLY ISSUED TO *YOU* UNDER THE POLICY. IT OUTLINES THE POLICY FEATURES. THE FOLLOWING PAGES PROVIDE A COMPLETE DESCRIPTION OF THE PROVISIONS OF *YOUR* CERTIFICATE.
SOBC

ELIGIBILITY AND EFFECTIVE DATES

Are You eligible for this insurance?

All full-time hourly employees working in the United States of America who are *Actively at Work* for the Employer and who have completed the waiting period required by the Employer as set forth in the *Schedule of Benefits*.

A full-time employee is one who regularly works a minimum of 32.5 hours per week for the Employer. Independent contractors, part-time, seasonal, temporary and leased employees are not eligible.

The waiting period is stated in the *Schedule of Benefits*.
CDI-4AA

When does Your insurance become effective?

If *You* are eligible as of the Policy Effective Date, *Your* insurance shall take effect on such Date. If *You* become eligible after the Policy Effective Date, *Your* insurance shall become effective on the date *You* become eligible.

If, because of *Injury* or *Sickness*, *You* are eligible but not *Actively at Work* on the date the insurance would otherwise take effect, it will take effect on the day *You* return to *Active Work*.
CDI-5AA

Who pays for Your coverage?

Your Employer pays the entire cost of *Your* coverage.
CDI-6AA

What happens if We are replacing an existing contract?

Effect on *Actively at Work* Provision

If *You* were insured under the Prior Policy on the day before the Policy Effective Date, *You* may be covered by the Policy even if *You* fail to satisfy the *Actively at Work* requirement as stated in the *Are You eligible for this insurance?* provision. *You* will receive credit for time covered under the Prior Policy. This credit will be applied toward satisfaction of service waiting periods, *Elimination Period*s or any other periods of the same or similar provisions under the Policy.

Effect on Benefits

If *You* do not satisfy the *Actively at Work* requirement, *You* may still be eligible for benefits under the Policy as follows:

> The benefits payable under the Policy will be the benefit which would have been payable under the terms of the Prior Policy if it had remained in force. The benefits payable under the Policy will be reduced by any benefits paid under the Prior Policy for the same *Disability*.

Benefits will end on the earliest of the following:

1) the date that benefits would terminate in accordance with the provisions of the Policy; or
2) the date that benefits would terminate under the Prior Policy if it had remained in force.

The Prior Policy is the group disability insurance policy issued to the Employer by MET LIFE whose coverage terminated as of the Policy Effective Date.
CDI-7AA

SHORT TERM DISABILITY BENEFITS

How do We define Disability?

Disability or *Disabled* means that *You* satisfy the Occupation Qualifier or the Earnings Qualifier as defined below.
CDI-9AA

Occupation Qualifier

Disability means that *Injury* or *Sickness* causes physical or mental impairment to such a degree of severity that *You* are:

1) continuously unable to perform the *Material and Substantial Duties* of *Your Regular Job*; and
2) not *Gainfully Employed*.

CDI-10CB

Earnings Qualifier

You may be considered *Disabled* during and after the *Elimination Period* in any week in which *You* are *Gainfully Employed*, if an *Injury* or *Sickness* is causing physical or mental impairment to such a degree of severity that *You* are unable to earn more than 80% of *Your Weekly Earnings* in any occupation for which *You* are qualified by education, training or experience.

You are not considered to be *Disabled* if *You* are able to earn more than 80% of *Your Weekly Earnings*. Salary, wages, partnership or proprietorship draw, commissions, bonuses, or similar pay, and any other income *You* receive or are entitled to receive will be included. Sick pay and salary continuance payments will not be included. Any lump sum payment will be prorated, based on the time over which it accrued or the period for which it was paid.

CDI-13AB

Loss of Professional License or Certification

If *You* require a professional license or certification for *Your* job, loss of that professional license or certification does not in and of itself constitute *Disability* under the Occupation Qualifier or the Earnings Qualifier.

CDI-14AA

What is the Elimination Period and how is it satisfied?

The *Elimination Period* begins on the first work day *You* become *Disabled*. It is a period of continuous *Disability* which must be satisfied before *You* are eligible to receive benefits from *Us*. *You* must be continuously *Disabled* through *Your Elimination Period*.

Can You satisfy Your Elimination Period if You are working?

You can satisfy *Your Elimination Period* if *You* are working, provided *You* meet the definition of *Disability*.

CDI-15BA(Westinghouse) SUBJECT TO DEPARTMENT OF INSURANCE APPROVAL

What Disability Benefit are You eligible to receive?

If *You* are *Disabled*, *You* are eligible to receive one of the following at any given time:

1) an *STD Weekly Benefit*; or
2) a Work Incentive Benefit.

While *You* are *Disabled*, *You* might be eligible to receive one or the other of the above, but *You* cannot receive more than one of these benefits at the same time.

CDI-16AA

What is Your STD Benefit and how is it calculated?

Your STD Weekly Benefit will be based on *Your Weekly Earnings* as reported to *Us* by *Your* Employer and for which premium has been paid.

An *STD Weekly Benefit* will be provided after the end of the *Elimination Period* if *You* are *Disabled* according to the Occupation Qualifier provision.

We will calculate *Your Gross STD Weekly Benefit* amount as follows:

1) Refer to the benefit schedule and find your hourly rate.
2) Find the corresponding benefit to your hourly rate.
3) This is *Your Gross STD Weekly Benefit*.
4) Subtract the Deductible Sources of Income from *Your Gross STD Weekly Benefit*. The resulting figure is *Your Net STD Weekly Benefit*.

If a benefit is payable for less than one week, it will be prorated for each day of *Disability*.

CDI-17AB

How do We *define Earnings?*

Weekly Earnings will equal the greater of *your* rate of record *You* were receiving from *Your* Employer on the *Date of Disability* or the basic hourly rate as of September 1st of the calendar year prior to the plan year. It includes:

1) employee contributions made through a salary reduction agreement with *Your* Employer to an IRC Section 401(k), 403(b), 457 deferred compensation plan, or any other qualified or non-qualified employee *Retirement Plan* or deferred compensation arrangement; and
2) amounts contributed to *Your* fringe benefits according to a salary reduction arrangement under an IRC Section 125 plan.

It does not include:

1) commissions;
2) bonuses;
3) overtime pay;
4) *Your* Employer's contribution on *Your* behalf to a *Retirement Plan* or deferred compensation arrangement; or any other extra compensation.

CDI-19AAWhat are the Deductible Sources of Income?

The *Gross Weekly Benefit* under this policy shall be reduced by *Disability* benefits paid, payable, or for which there is a right under:

1) Any sick leave or salary continuance plan provided by or through the Employer;
2) Any Statutory Disability Benefit Law.

CDI-20AB

What other sources of income are not deductible?

We will not reduce *Your Gross STD Weekly Benefit* by any of the following:

1) deferred compensation arrangements such as 401(k), 403(b) or 457 plans;
2) credit *Disability* insurance;
3) pension plans for partners;
4) military pension and *Disability* income plans;
5) franchise *Disability* income plans;
6) individual *Disability* income plans;
7) a *Retirement Plan* from another Employer;
8) profit sharing plans;
9) thrift or savings plans;
10) individual retirement account (IRA);
11) tax sheltered annuity (TSA);
12) stock ownership plan.

CDI-21AB

Can You work and still receive benefits?

While *Disabled, You* may qualify for the Work Incentive Benefit.

CDI-22AA

Work Incentive Benefit

A Work Incentive Benefit will be provided if *You* are *Disabled* and *Gainfully Employed* after the end of the *Elimination Period,* or after a period during which *You* received *STD Weekly Benefits*.

The Work Incentive Benefit will be equal to the *Net STD Weekly Benefit* amount less that amount of *Your Disability Earnings* which, when combined with *Your Net STD Weekly Benefit*, exceeds 100% of *Your Weekly Earnings* prior to *Disability*.

The Work Incentive Benefit will cease on the earliest of the following:

1) the date *You* are no longer *Disabled;* or
2) the end of the *Maximum Period Payable*.

CDI-23BB

How long will You receive benefits under this program?

We will send *You* a payment for each week of *Disability* for the *Maximum Period Payable* as shown in the *Schedule of Benefits*. Payment of benefits is also subject to any benefit duration limitation pertaining to *Your Disability*.
CDI-27AB

What happens if Your Disability recurs?

If *Disability* for which benefits were payable ends but recurs due to the same or related causes less than 30 days after the end of a prior *Disability*, it will be considered a resumption of the prior *Disability*. Such recurrent *Disability* shall be subject to the provisions of the Policy that were in effect at the time the prior *Disability* began.

Disability which recurs more than 30 days after the end of a prior *Disability* are subject to:

1) a new *Elimination Period*;
2) a new *Maximum Period Payable*; and
3) the other provisions of the Policy that are in effect on the date the *Disability* recurs.

Disability must recur while *Your* coverage is in force under the Policy.
CDI-28AA

EXCLUSIONS AND LIMITATIONS

What are the exclusions and limitations under this program?

The Policy does not cover any loss caused by, contributed to, or resulting from:
CDIX-1AA

- declared or undeclared war or an act of either;
CDIX-2AA

- attempted suicide, while sane or insane, or intentional self-inflicted *Injury* or *Sickness*;
CDIX-5AA

- commission of or attempt to commit an act which is a felony in the jurisdiction in which the act occurred;
CDIX-6AA

- Occupational *Injury* or *Sickness*;
CDIX-10AA

Benefits are not payable for any period during which *You* are confined to a penal or correctional institution if the period of confinement exceeds 30 days.
CDIX-12AA

TERMINATION OF COVERAGE

When will Your insurance terminate?

Your coverage will terminate on the earliest of the following dates:

1) the date the Policy is terminated; or
2) the date at the end of the period for which premium has been paid, subject to the Grace Period, if the Employer fails to pay the required premium for *You*, except for an inadvertent error; or
3) the date *You*:
    a) are no longer a member of a class eligible for this insurance, or
    b) withdraw from the program, or
    c) are retired or pensioned, or
    d) cease work because of a leave of absence, furlough, layoff, or temporary work stoppage due to a labor dispute, unless *We* and the Employer have agreed in writing in advance of the leave to continue insurance during such period.

Termination will not affect a covered loss which began before the date of termination.
CDI-30AB37

Will coverage be continued if You are eligible for leave under FMLA?

In the event *You* are eligible for and *Your* Employer approves a leave under the Family and Medical Leave Act of 1993 (FMLA), *Your* insurance will continue for a period of up to 12 weeks following the date the leave begins, provided the required premium continues to be paid.

You are eligible for leave under this Act in order to provide care:

1) After the birth of a child; or
2) After the legal adoption of a child; or
3) After the placement of a foster child in *Your* home; or
4) To a *Spouse*, child or parent due to their serious illness; or
5) For *Your* own serious health condition.

While granted a Family or Medical Leave of Absence:

1) The Employer must remit the required premium according to the terms of the policy; and
2) Coverage will terminate if *You* do not return to work as scheduled according to the terms of *Your* agreement with the Employer.

CDI-31AB

FILING A CLAIM

What are the Claim Filing Requirements?

Initial Notice of Claim

We ask that *You* notify *Us* of *Your* claim as soon as possible, so that *We* may make a timely decision on *Your* claim. The Employer can assist *You* with the appropriate telephone number and address of *Our* Claim Department. *You* must send *Us* written notice of *Your Disability* within 30 days of the *Date of Disability*, or as soon as reasonably possible. Notice may be sent to *Our* Claim Department, the CNA Home Office, CNA Plaza, Chicago, Illinois 60685 or given to *Our* Agent.

Written Proof of Loss

Within 15 days of *Our* being notified in writing of *Your* claim, *We* will supply *You* with the necessary claim forms. The claim form is to be completed and signed by *You*, the Employer and *Your Doctor*. If *You* do not receive the appropriate claim forms within 15 days, then *You* will be considered to have met the requirements for written proof of loss if *We* receive written proof, which describes the occurrence, extent and nature of loss as stated in the Proof of *Disability* provision.

Time Limit for Filing *Your* Claim

You must furnish *Us* with written proof of loss within 90 days after the end of *Your Elimination Period*. The length of the *Elimination Period* is stated in the *Schedule of Benefits*. If it is not possible to give *Us* written proof within 90 days, the claim is not affected if the proof is given as soon as possible. However, unless *You* are legally incapacitated, written proof of loss must be given no later than 1 year after the time proof is otherwise due.

No benefits are payable for claims submitted more than 1 year after the time proof is due. However, *You* can request that benefits be paid for late claims if *You* can show that:

1) It was not reasonably possible to give written proof during the 1 year period, and
2) Proof of loss satisfactory to *Us* was given as soon as was reasonably possible.

Proof of *Disability*

The following items, supplied at *Your* expense, must be a part of *Your* proof of loss. Failure to do so may delay, suspend or terminate *Your* benefits.

1) The date *Your Disability* began;
2) The cause of *Your Disability*;
3) The prognosis of *Your Disability*;
4) Proof that *You* are receiving *Appropriate and Regular Care* for *Your* condition from a *Doctor*, who is someone other than *You* or a member of *Your* immediate family, whose specialty or expertise is the most appropriate for *Your* disabling condition(s) according to *Generally Accepted Medical Practice*.

5) Objective medical findings which support *Your Disability*. Objective medical findings include but are not limited to tests, procedures, or clinical examinations standardly accepted in the practice of medicine, for *Your* disabling condition(s).
6) The extent of *Your Disability*, including restrictions and limitations which are preventing *You* from performing *Your Regular Job*.
7) Appropriate documentation of *Your* Weekly *Earnings*. If applicable, regular monthly documentation of *Your Disability Earnings*.
8) If *You* were contributing to the premium cost, *Your* Employer must supply proof of *Your* appropriate payroll deductions.
9) The name and address of any *Hospital* or *Health Care Facility* where *You* have been treated for *Your Disability*.
10) If applicable, proof of incurred costs covered under other benefits included in the Policy.

Continuing Proof of *Disability*

You may be asked to submit proof that *You* continue to be *Disabled* and are continuing to receive *Appropriate and Regular Care* of a *Doctor*. Requests of this nature will only be as often as *We* feel reasonably necessary. If so, this will be at *Your* expense and must be received within 30 days of *Our* request. Failure to do so may delay, suspend or terminate *Your* benefits.

Examination

At *Our* expense, *We* have the right to have *You* examined as often as reasonably necessary while the claim continues. Failure to comply with this examination may deny, suspend or terminate benefits, unless *We* agree *You* have a valid and acceptable reason for not complying.

Authorization and Documentation *You* will be asked to supply

1) *You* will be required to provide signed authorization for *Us* to obtain and release all reasonably necessary medical, financial or other non-medical information which support *Your Disability* claim. Failure to submit this information may deny, suspend or terminate *Your* benefits.
2) *You* will be required to supply proof that *You* have applied for other Deductible Income Benefits such as Workers' Compensation or Social Security *Disability* benefits, when applicable.
3) *You* will be required to notify *Us* when *You* receive or are awarded other Deductible Income Benefits. *You* must tell *Us* the nature of the income benefit, the amount received, the period to which the benefit applies, and the duration of the benefit if it is being paid in installments.

CDI-36AB

Time of Payment of Claim

As soon as *We* have all necessary substantiating documentation for *Your Disability* claim, *Your* benefit will be paid on a weekly basis, so long as *You* continue to qualify for it.

We will pay benefits to *You* unless otherwise indicated. If *You* die while *Your* claim is open, any due and unpaid *Disability* benefit will be paid to *Your* named beneficiary, if any.

If there is no surviving beneficiary, payment may be made, at *Our* option, to the surviving person or persons in the first of the following classes of successive preference beneficiaries: *Your*: 1) *Spouse*; 2) children including legally adopted children; 3) parents; 4) brothers or sisters; or 5) estate.

If any benefit is payable to an estate, a minor or a person not competent to give a valid release, *We* may pay up to $1,000 to any relative or beneficiary of *Yours* whom *We* deem to be entitled to this amount. *We* will be discharged to the extent of such payment made by *Us* in good faith.

CDI-37AB

Can you assign Your benefits?

Your benefits are not assignable, which means that *You* may not transfer *Your* benefits to anyone else.

CDI-38AA

What will happen if a claim is overpaid?

A claim overpayment can occur when *You* receive a retroactive payment from a Deductible Source of Income; when *We* inadvertently make an error in the calculation of *Your* claim; or if fraud occurs.

In an overpayment situation, *We* will determine the method by which the repayment is made. *You* will be required to sign an agreement with *Us* which details the source of the overpayment, the total amount *We* will recover and the method of recovery.

The overpayment amount equals the amount *We* paid in excess of the amount *We* should have paid under the Policy.
CDI-39AA

Subrogation – Right of Reimbursement

When any claim payment is made, *We* reserve any and all rights to subrogation and/or reimbursement to the fullest extent allowed by statute and customary practice. Any party to this contract shall not perform any act that will prejudice such rights without prior agreement with *Us*.

We will bear any expenses associated with *Our* pursuit of subrogation or recovery.
CDI-41AA

Fraud

Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and may subject such person to criminal and civil penalties. Such penalties include, but are not limited to fines, denial or termination of insurance benefits, recovery of any amounts paid, civil damages, criminal prosecution and confinement in state prison.
CDI-42AA

UNIFORM PROVISIONS

Entire Contract; Changes

The Policy, the Employer's application, the employee's certificate of coverage, and *Your* application, if any, and any other attached papers, form the entire contract between the parties. Coverage under the Policy can be amended by mutual consent between the Employer and *Us*. No change in the Policy is valid unless approved in writing by one of *Our* officers. No agent has the right to change the Policy or to waive any of its provisions.

Statements on the Application

Any statement made by the Employer or *You*, except for fraudulent misstatements, is considered a representation and not a warranty. No such statement shall void the insurance, reduce the benefits or be used in defense to a claim unless it is in writing signed by the Employer or *You* and a copy furnished to the Employer or *You* or *Your* beneficiary, whoever made the statement. No statement of the Employer will be used to void the Policy after it has been in force for 2 years. No statement of *Yours* will be used in defense of a claim after *You* have been insured for 2 years, except for fraudulent misstatements.

Legal Actions

No legal action of any kind may be filed against *Us* :

1) within the 60 days after proof of *Disability* has been given; or
2) more than 3 years after proof of *Disability* must be filed, unless the law in the state where *You* live allows a longer period of time.

Conformity with State Statutes

If any provision of the Policy conflicts with the statutes of the state in which the policy was issued or delivered, it is automatically changed to meet the minimum requirements of the statute.
CDI-40AB37

General Provisions

We have the right to inspect all of the Employer's records on the Policy at any reasonable time. This right will extend until:

1) 2 years after termination of the Policy; or
2) all claims under the Policy have been settled,

whichever is later.

The Policy is in the Employer's possession and may be inspected by *You* at any time during normal business hours at the Employer's office.

The Policy is not in lieu of and does not affect any requirements for coverage by Workers' Compensation Insurance.

CDI-43AB

DEFINITIONS

The following are key words and phrases used in this certificate. When these words and phrases, or forms of them, are used, they are capitalized and italicized in the text. As *You* read this certificate, refer back to these definitions.

Actively at Work or ***Active Work*** means that *You* must be:

1) working at the Employer's usual place of business, or on assignment for the purpose of furthering the Employer's business; and
2) performing the *Material and Substantial Duties* of *Your Regular Job* on a full-time basis.

CDID-1AB

Appropriate and Regular Care means that *You* are regularly visiting a *Doctor* as frequently as medically required to meet *Your* basic health needs. The effect of the care should be of demonstrable medical value for *Your* disabling condition(s) to effectively attain and/or maintain *Maximum Medical Improvement*.
CDID-4AA

Date of Disability is the date *We* determine *Your Injury* or *Sickness* impairs *Your* ability to perform *Your Regular Job*.
CDID-5AA

Disability or ***Disabled*** means that *You* satisfy either the Occupation Qualifier or the Earnings Qualifier.
CDID-6AA

Disability Earnings is the wage or salary *You* earn from *Gainful Employment* after a *Disability* begins. It includes partnership or proprietorship draw, commissions, bonuses, or similar pay, and any other income *You* receive or are entitled to receive. It does not include Social Security, sick pay, salary continuance payments or any other *Disability* payment *You* receive as a result of *Your Disability*. Any lump sum payment will be prorated, based on the time over which it accrued or the period for which it was paid.
CDID-7AB

Doctor means a person legally licensed to practice medicine, psychiatry, psychology or psychotherapy, who is neither *You* nor a member of *Your* immediate family. A licensed medical practitioner is a *Doctor* if applicable state law requires that such practitioners be recognized for purposes of certification of *Disability*, and the treatment provided by the practitioner is within the scope of his or her license.
CDID-8AA

Elimination Period means the number of calendar days at the beginning of a continuous period of *Disability* for which no benefits are payable. The *Elimination Period* is shown in the *Schedule of Benefits*.
CDID-9AA

Gainful Employment or ***Gainfully Employed*** means the performance of any occupation for wages, remuneration or profit, for which *You* are qualified by education, training or experience on a full-time or part-time basis, for the Employer or another employer, and which *We* approve and for which *We* reserve the right to modify approval in the future.
CDID-10AA

Generally Accepted Medical Practice or ***Generally Accepted in the Practice of Medicine*** means care and treatment which is consistent with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies.
CDID-11AA

Gross STD Weekly Benefit means that benefit shown in the *Schedule of Benefits* which applies to *You*.
CDID-20AGross

Hospital or Health Care Facility is a legally operated, accredited facility licensed to provide full-time care and treatment for the condition(s) causing *Your Disability*. It is operated by a full-time staff of licensed physicians and registered nurses. It does not include facilities which primarily provide custodial, educational or rehabilitative care.
CDID-12AA

Injury means bodily injury caused by an accident which results, directly and independently of all other causes, in *Disability* which begins while *Your* coverage is in force.
CDID-13AA

Insured Employee means an employee whose insurance is in force under the terms of the Policy.
CDID-14AA

Male pronoun, whenever used, includes the female.
CDID-16AA

Material and Substantial Duties means the necessary functions of *Your Regular Job* which cannot be reasonably omitted or altered.
CDID-17AA

Maximum Medical Improvement is the level at which, based on reasonable medical probability, further material recovery from, or lasting improvement to, an *Injury* or *Sickness* can no longer be reasonably anticipated.
CDID-18AA

Maximum Period Payable, as shown in the *Schedule of Benefits*, means the longest period of time that *We* will make payments to *You* for any one period of *Disability*.
CDID-32AA

Weekly Benefit means that benefit shown in the *Schedule of Benefits* which applies to *You*.
CDID-20AA

Net STD Weekly Benefit means the *Gross Short Term Disability Weekly Benefit* less the Deductible Sources of Income.
CDID-20ANet

Regular Job means the job that *You* are performing for income or wages on *Your Date of Disability*.
CDID-22BA

Retirement Plan means a plan which provides retirement benefits to employees and is not funded wholly by employee contributions.
CDID-24AA

Schedule of Benefits means the schedule which is a part of this certificate.
CDID-28AA

STD means Short Term *Disability*.
CDID-34AA

Sickness means sickness or disease causing *Disability* which begins while *Your* coverage is in force.
CDID-26AA

We, Our and ***Us*** mean the CNA Group Life Assurance Company, Chicago, Illinois.
CDID-29AA

You, Your and ***Yours*** means the employee to whom this certificate is issued and whose insurance is in force under the terms of the Policy.
CDID-30AA

IMPORTANT ERISA WELFARE PLAN INFORMATION

The following section contains information provided to You at the request of the Plan Administrator of Your Plan to meet certain requirements of the Employee Retirement Income Security Act of 1974, as amended, (ERISA). All inquiries related to the following material should be referred directly to Your Plan Administrator.

DISCRETIONARY AUTHORITY

The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments thereto. The Plan Administrator and other plan fiduciaries have discretionary authority to determine Your eligibility to participate in the Westinghouse Electric Company Welfare Benefits Plan. The Plan Administrator has delegated sole discretionary authority to CNA Group Life Assurance Company to determine Your eligibility for benefits as it relates to Disability and to interpret the terms and provisions of the Plan and any policy issued in connection with it.

SUMMARY PLAN DESCRIPTION (SPD) AND ERISA STATEMENT OF RIGHTS

The following sections contain information provided to You by the Plan Administrator of Your Plan to meet the requirements of the Employee Retirement Income Security Act of 1974, as amended. It does not constitute a part of the Plan, nor of any insurance policy issued in connection with it. All inquiries relating to the following material should be referred directly to Your Plan Administrator.

SUMMARY PLAN DESCRIPTION

Name of Plan

The plan for which this Summary Plan Description is provided is known as the Westinghouse Government Services Company, LLC Group Disability Income Insurance Plan, herein referred to as the "Plan".

Maintenance of Plan

The Plan is maintained by:

Employer Identification Number and Plan Number

The Employer identification number (EIN) assigned by the Internal Revenue Service to the Plan Sponsor is 52-2140933.

The Plan Number assigned by the Plan sponsor is 501.

Type of Welfare Plan

The Plan is a group disability income insurance plan.

Administration of Plan

The Plan is administered by the Plan Administrator through an insurance contract purchased from CNA Group Life Assurance Company. Certain ministerial functions are performed on behalf of the Plan by CNA Group Life Assurance Company. These functions include, but are not limited to, administration and payment of claims, determination of Your eligibility under the Plan, premium billing and policy and certificate issuance.

Plan Sponsor/Administrator *(Herein referred to as the Administrator)*

Telephone Number: (412) 374-2257

The Administrator and other Plan fiduciaries have discretionary authority to interpret the terms of the Plan and to determine Your eligibility for and entitlement to benefits in accordance with the Plan. With respect to making benefit decisions, the Plan Administrator has delegated sole discretionary authority to CNA Group Life Assurance Company to determine Your eligibility for and entitlement to benefits under the Plan and to interpret the terms and provisions of any insurance policy issued in connection with the Plan.

Agent for Service of Legal Process

The person designated as agent for service of legal process upon the Plan is:

In addition, service of process may be made upon the Administrator.

Eligibility and Benefits

The Plan's requirements respecting eligibility for participation, the conditions pertaining to eligibility to receive benefits and a description or summary of the benefits are listed in the certificate portion of this booklet.

Circumstances Which May Affect Benefits

Circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of any benefits are listed in the certificate portion of this booklet.

The Plan Administrator reserves the right to modify, amend, or terminate the Plan in whole or in part. Such right may be exercised at any time and at the Plan Administrator's sole discretion.

Right of Recovery Due to Benefit Overpayment

If, for any reason, a benefit is paid under the Plan which is larger than the amount allowed in accordance with the Plan, the Plan reserves the right to recover the excess amount from the person or agency that received such overpayment.

Sources of Plan Contributions

Contributions to the Plan are made by the employer.

Medium for Providing Benefits

Benefits under the Plan are provided in accordance with the provisions of Group Insurance Policy Number SR-83115809 issued by CNA Group Life Assurance Company, CNA Plaza, Chicago, Illinois 60685. Benefits available under the Plan are not guaranteed under the Group Insurance Policy.

Date of End of Plan's Fiscal Year

The date of the end of each year for purposes of maintaining the Plan's fiscal records is DECEMBER 31.

Claim Procedures

1) **Presenting Claims for Benefits**

   Claim forms may be obtained from: Employer.

   Please see Your insurance certificate or booklet for the requirements of the Group Insurance Policy as to notice of claims.

   The insurance company will provide notice of benefit determination no later than 45 days after receipt of the claim. This period may be extended by 30 days if it is determined that matters beyond the control of the plan make such an extension necessary. You will receive written notification of the extension and the date by which the insurance company expects to decide your claim prior to the end of the initial 45-day period. If, prior to the end of the 30-day extension period, it is determined that a decision cannot be made due to matters beyond the control of the plan, the period for making the decision may be extended for up to an additional 30 days. You will be notified in writing of the additional extension and the date by which the insurance company expects to decide your claim prior to the end of the initial 30-day extension period. Each notice of extension will explain the standards on which entitlement to benefits is based, the reasons for the delay, and the additional information needed to make a decision on the claim. If the extension is due to your failure to submit information necessary to decide the claim, the time limitations for the insurance company will be tolled from the date the notification of the extension is sent until the date you respond to the request for additional information. You will have 45 days within which to provide the necessary information.

2) **Claims Denial Procedure**

   Any denial of a claim for benefits will be provided by the insurance company and consist of a written explanation which will include:

   i) the specific reasons for the denial;
   ii) reference to the pertinent plan provisions upon which the denial is based;
   iii) a description of any additional information You might be required to provide and explanation of why it is needed; and
   iv) an explanation of the Plan's claim review procedure.

   You, Your beneficiary (when an appropriate claimant), or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a full and fair review to the insurance company. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed, and comments and issues outlining the basis of the appeal may be submitted in writing. You may have representation throughout the review procedure. A request for a review must be filed by 180 days after receipt of the written notice of denial of a claim. The full and fair review will be held and a decision rendered by the insurance company no longer than 45 days after receipt of the request for the review.

   If there are special circumstances, the decision will be made as soon as possible, but not later than 90 days after receipt of the request for the review. If such an extension of time is needed, You will be notified in writing prior to the beginning of the time extension period. The decision after Your review will be in

writing and will include specific reasons for the decision as well as specific references to the pertinent Plan provisions on which the decision is based.

ERISA AND EFFECT ON EMPLOYMENT

No one may fire You or otherwise discriminate against You in order to prevent You from obtaining a welfare benefit You are entitled to under the Plan or exercising Your rights under ERISA. However, nothing listed herein, or in any Plan document or insurance policy issued in connection with the Plan, shall be construed to say or imply that Your participation in the Plan is a guarantee of Your continued employment with Your Employer. Your employment status shall not be affected by Your participation in the Plan or exercise of Your rights under ERISA.

YOUR RIGHTS UNDER ERISA

As a participant in the above described Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to the following rights and protections under the law.

Receive Information About Your Plan and Benefits

As a participant in an ERISA covered Plan, You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your Employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

Enforce Your Rights

If Your claim for a welfare benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court. In addition, if You disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order you to pay these costs and fees, for example, if it finds Your claim is frivolous.

Assistance with Your Questions

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

IMPORTANT NOTICE FOR NON-ENGLISH SPEAKING EMPLOYEES

Para Empleados Que No Hablan Inglés

Este documento contiene un resumen en inglés de los derechos y beneficios que le corresponden bajo el plan de seguro de accidente grupal creado y mantenido por su empresa. Si tiene alguna pregunta acerca de la información contenida en el documento, communiquese con el Administrador para obtener ayuda. La dirección del Administrador es:

Numero de Teléfono: (412) 374-2257

ERISA

CNA Group Life Assurance Company

CNA Plaza
Chicago, Illinois 60685

A Stock Company

Having issued Group Policy No. SR-83115808

to

Westinghouse Government Services Company, LLC

(herein called the Employer)

CERTIFICATE OF INSURANCE

CERTIFIES that *You* are insured provided that *You* qualify under the ELIGIBILITY provision, become insured and remain insured in accordance with the terms of the Policy. *Your* insurance is subject to all the definitions, limitations and conditions of the Policy. It takes effect on the effective date indicated in the EFFECTIVE DATE provision. This certificate, however, is not the Policy. It is merely evidence of insurance provided under the Policy. The Policy can be amended by mutual consent between the Employer and *Us*.

This certificate replaces and cancels any other certificate previously issued to *You* under the Policy.
CDI-1AA

Signed for the CNA Group Life Assurance Company

Chairman of the Board

Group Long Term Disability Certificate

NON-PARTICIPATING

SBDI-C

TABLE OF CONTENTS

Note: All terms in *italics* are listed and defined in the Definitions section or within the certificate itself.
CDI-3AA

SCHEDULE OF BENEFITS

Effective as of: January 1, 2003

Employer:	Westinghouse Government Services Company, LLC or any subsidiary or affiliate that, by action of the Board of Directors, and with the approval of the Board of Directors of Westinghouse, has adopted or shall adopt the Westinghouse Welfare Benefits Plan.
Policy Number:	SR-83115808
Policy Effective Date:	January 1, 2003
Class 1 Eligibility:	All full-time employees (excluding employees represented by the International Brotherhood of Boilermakers, Iron Ship Builders, Blacksmiths, Forgers and Helpers, Lodge #558 and Lodge # 651) working in the United States of America and all full-time named expatriated United States citizens who are *Actively at Work* for the Employer and who have completed the waiting period required by the Employer as set forth in the Waiting Period section below . A full-time employee is one who regularly works a minimum of 32.5 hours per week for the Employer. Independent contractors, part-time, seasonal, temporary and leased employees are not eligible.
Class 2 Eligibility:	All full-time employees represented by the International Brotherhood of Boilermakers, Iron Ship Builders, Blacksmiths, Forgers and Helpers, Lodge #558 and Lodge #651 working for Westinghouse in the United States of America and who have completed the waiting period required by the Employer as set forth in the Waiting Period section below . A full-time employee is one who regularly works a minimum of 32.5 hours per week for the Employer. Independent contractors, part-time, seasonal, temporary and leased employees are not eligible.
Waiting Period:	For employees in an eligible group on or before the Policy Effective Date who have not completed 30 days of continuous active, full-time employment: the 1st of the month after 30 Days of continuous active, full-time employment For employees entering an eligible group after the Policy Effective Date: the 1st of the month after 30 Days of continuous active, full-time employment
Elimination Period:	The later of 180 Days or the end of the period for which you receive your salary continuance, including vacation pay, and including the period for which you are eligible for Short Term Disability benefits under the Westinghouse Government Services Company, LLC Welfare Benefits Plan. 180 Days with respect to the Catastrophic Disability Benefit
Minimum Monthly Benefit:	$150

Class 1

LTD Monthly Benefit: 60% Option	60% of *Monthly Earnings* to a maximum benefit of $10,000 per month subject to reduction by deductible sources of income or *Disability Earnings*.
LTD Monthly Benefit: 70% Option	70% of *Monthly Earnings* to a maximum benefit of $11,667 per month subject to reduction by deductible sources of income or *Disability Earnings*.

Class 2

LTD Monthly Benefit: 60% Option Only	60% of *Monthly Earnings* to a maximum benefit of $10,000 per month subject to reduction by deductible sources of income or *Disability Earnings*.
Social Security Offset Method:	Family Social Security
Employer Contribution:	0% of premium

Maximum Period Payable:

Age on Date Disability Commences	Maximum Period Payable
Age 61 or younger	To *Your* 65th birthday
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 or older	12 months

Catastrophic Disability Benefit: 12 months

OTHER FEATURES

The following other features are included:

- Waiver of Premium
- Pre-existing Conditions: Limited Benefit
- Work Incentive Benefit
- Minimum Benefit
- Recurrent Disability
- FMLA Coverage Extension
- Worksite Modification Benefit
- Vocational Rehabilitation Service
- Social Security Assistance
- Catastrophic Disability Benefit
- Continuity of Coverage

THIS SCHEDULE OF BENEFITS CANCELS AND REPLACES ALL OTHER SCHEDULES PREVIOUSLY ISSUED TO *YOU* UNDER THE POLICY. IT OUTLINES THE POLICY FEATURES. THE FOLLOWING PAGES PROVIDE A COMPLETE DESCRIPTION OF THE PROVISIONS OF *YOUR* CERTIFICATE.

SOBC

ELIGIBILITY AND EFFECTIVE DATES

Class 1

Are You eligible for this insurance?

All full-time employees (excluding the employees represented by the International Brotherhood of Boilermakers, Iron Ship Builders, Forgers and Helpers, Lodge #558 and Lodge #651) working in the United States of America and all full-time named expatriated United States citizens who are *Actively at Work* for the Employer and who have completed the waiting period required by the Employer as set forth in the *Schedule of Benefits*.

A full-time employee is one who regularly works a minimum of 32.5 hours per week for the Employer. Independent contractors, part-time, seasonal, temporary and leased employees are not eligible.

The waiting period is stated in the *Schedule of Benefits*.
CDI-4AA

Class 2

Are You eligible for this insurance?

All full-time employees represented by the International Brotherhood of Boilermakers, Iron Ship Builders, Forgers and Helpers, Lodge #558 and Lodge #651 working for Westinghouse in the United States of America and who have completed the waiting period required by the Employer as set forth in the *Schedule of Benefits*.

A full-time employee is one who regularly works a minimum of 32.5 hours per week for the Employer. Independent contractors, part-time, seasonal, temporary and leased employees are not eligible.

The waiting period is stated in the *Schedule of Benefits*.
CDI-4AA

When does Your insurance become effective?

If *You* enroll on or before the Policy Effective Date, *Your* insurance shall take effect on such Date. If *You* enroll after the Policy Effective Date but within 31 days of becoming eligible, *Your* insurance will take effect on the date *Your* signed enrollment form is received by *Your* Employer.

If *You* enroll more than 31 days after becoming eligible, *Your* insurance will take effect after *We* approve such Evidence of Insurability as *We* require. *You* will be notified of *Your* effective date.

If, because of *Injury* or *Sickness*, *You* are eligible but not *Actively at Work* on the date the insurance would otherwise take effect, it will take effect on the day after *You* return to *Active Work* for a continuous period equal to the time *You* were not *Actively Working*. This return to *Active Work* requirement will not exceed 30 days.
CDI-5AA

Evidence of Insurability

If *You* are required to submit Evidence of Insurability, *You* must:

1) Complete and sign a health and medical history form provided by *Us;*
2) Submit to a medical examination, if requested;
3) Submit verification of *Monthly Earnings*;
4) Provide any additional information and attending physicians' statements that *We* require; and
5) Furnish all such evidence at *Your* own expense.

CDI-47AA

Who pays for Your coverage?

You pay the entire cost of *Your* coverage.
CDI-6AA

Is premium payable while You receive benefits?

We will waive premium for *You* during a period of *Disability* for which the *LTD Monthly Benefit* is payable under the Policy. Premium payment is required during *Your Elimination Period* or any other period when the *LTD Monthly Benefit* is not payable under the Policy.
CDI-45AA

What happens if We are replacing an existing contract?

Effect on *Actively at Work* Provision

If *You* were insured under the Prior Policy on the day before the Policy Effective Date, *You* may be covered by the Policy even if *You* fail to satisfy the *Actively at Work* requirement as stated in the *Are You eligible for this insurance?* provision. *You* will receive credit for time covered under the Prior Policy. This credit will be applied toward satisfaction of service waiting periods, *Elimination Period*s or any other periods of the same or similar provisions under the Policy.

Effect on Benefits

If *You* do not satisfy the *Actively at Work* requirement, *You* may still be eligible for benefits under the Policy as follows:

The benefits payable under the Policy will be the benefit which would have been payable under the terms of the Prior Policy if it had remained in force. The benefits payable under the Policy will be reduced by any benefits paid under the Prior Policy for the same *Disability*.

Benefits will end on the earliest of the following:

1) the date that benefits would terminate in accordance with the provisions of the Policy; or
2) the date that benefits would terminate under the Prior Policy if it had remained in force.

The Prior Policy is the group disability insurance policy issued to the Employer by MET LIFE whose coverage terminated as of the Policy Effective Date.
CDI-7AA

Effect on Pre-existing Conditions

You will receive credit toward satisfaction of the *Pre-existing Condition* time periods under the Policy for the time *You* were covered under the Prior Policy. If, after applying the time covered under the Prior Policy, *Your Disability* is due to a *Pre-existing Condition*, benefits shall be the lesser of:

1) the benefits payable under the Policy; or
2) the benefits that would have been payable under the Prior Policy if it had remained in force, taking into account the *Pre-existing Condition* provision, if any, of the Prior Policy.

CDI-8AA

LONG TERM DISABILITY BENEFITS

How do We define Disability?

Disability or *Disabled* means that *You* satisfy the Occupation Qualifier or the Earnings Qualifier as defined below.
CDI-9AA

Occupation Qualifier

Disability means that during the *Elimination Period* and the following 12 months, *Injury* or *Sickness* causes physical or mental impairment to such a degree of severity that *You* are:

1) continuously unable to perform the *Material and Substantial Duties* of *Your Regular Job*; and
2) not *Gainfully Employed*.

CDI-10AB

After the *LTD Monthly Benefit* has been payable for 12 months, *Disability* means that *Injury* or *Sickness* causes physical or mental impairment to such a degree of severity that *You* are:

1) continuously unable to engage in any occupation for which *You* are or become qualified by education, training or experience; and
2) not *Gainfully Employed*.

CDI-11AB

Earnings Qualifier

You may be considered *Disabled* during and after the *Elimination Period* in any month in which *You* are *Gainfully Employed*, if an *Injury* or *Sickness* is causing physical or mental impairment to such a degree of severity that *You* are unable to earn more than 80% of *Your Monthly Earnings* in any occupation for which *You* are qualified by education, training or experience. On each anniversary of *Your Disability*, *We* will increase the *Monthly Earnings* by the lesser of the current annual percentage increase in *CPI-W* (Consumer Price Index-Wages), or 10%.

You are not considered to be *Disabled* if *You* are able to earn more than 80% of *Your Monthly Earnings*. Salary, wages, partnership or proprietorship draw, commissions, bonuses, or similar pay, and any other income *You* receive or are entitled to receive will be included. Sick pay and salary continuance payments will not be included. Any lump sum payment will be prorated, based on the time over which it accrued or the period for which it was paid.
CDI-13AB

Loss of Professional License or Certification

If *You* require a professional license or certification for *Your* occupation, loss of that professional license or certification does not in and of itself constitute *Disability* under the Occupation Qualifier or the Earnings Qualifier.
CDI-14AA

What is the Elimination Period and how is it satisfied?

The *Elimination Period* begins on the day *You* become *Disabled*. It is a period of continuous *Disability* which must be satisfied before *You* are eligible to receive benefits from *Us*. *You* must be continuously *Disabled* through *Your Elimination Period*.

If *You* temporarily recover and return to work, *We* will treat *Your Disability* as continuous if *You* return to work for a period of less than one-half the *Elimination Period* as shown in the *Schedule of Benefits* not to exceed 90 days. The days that *You* are not *Disabled* will not count toward *Your Elimination Period*.

Any increases *You* receive in *Monthly Earnings* during *Your* return to work period will not be taken into consideration when calculating *Your LTD Monthly Benefit*.

If *You* return to work for a period greater than one-half the *Elimination Period*, or 90 days, whichever is less, and become *Disabled* again, *You* will have to begin a new *Elimination Period*.

Can You satisfy Your Elimination Period if You are working?

You can satisfy *Your Elimination Period* if *You* are working, provided *You* meet the definition of *Disability*.
CDI-15AA

What Disability Benefit are You eligible to receive?

If *You* are *Disabled*, *You* are eligible to receive one of the following at any given time:

1) an *LTD Monthly Benefit*; or
2) a Work Incentive Benefit.

While *You* are *Disabled*, *You* might be eligible to receive one or the other of the above, but *You* cannot receive more than one of these benefits at the same time.
CDI-16AA

What is Your LTD Monthly Benefit and how is it calculated?

60% Option

Your LTD Monthly Benefit will be based on *Your Monthly Earnings* as reported to *Us* by *Your* Employer and for which premium has been paid.

An *LTD Monthly Benefit* will be provided after the end of the *Elimination Period* if *You* are *Disabled* according to the Occupation Qualifier provision.

We will calculate *Your Gross LTD Monthly Benefit* amount as follows:

1) Multiply *Your Monthly Earnings* by 60%.
2) The maximum *Gross LTD Monthly Benefit* is $10,000.
3) Compare the answers from Item 1 and Item 2. The lesser of these two amounts is *Your Gross LTD Monthly Benefit*.

4) Subtract the Deductible Sources of Income from *Your Gross LTD Monthly Benefit*. The resulting figure is *Your Net LTD Monthly Benefit*.

If a benefit is payable for less than one month, it will be paid on the basis of 1/30th of the *Net LTD Monthly Benefit* for each day of *Disability*.
CDI-17AB

70% Option

Your LTD Monthly Benefit will be based on *Your Monthly Earnings* as reported to *Us* by *Your* Employer and for which premium has been paid.

An *LTD Monthly Benefit* will be provided after the end of the *Elimination Period* if *You* are *Disabled* according to the Occupation Qualifier provision.

We will calculate *Your Gross LTD Monthly Benefit* amount as follows:

1) Multiply *Your Monthly Earnings* by 70%.
2) The maximum *Gross LTD Monthly Benefit* is $11,667.
3) Compare the answers from Item 1 and Item 2. The lesser of these two amounts is *Your Gross LTD Monthly Benefit*.
4) Subtract the Deductible Sources of Income from *Your Gross LTD Monthly Benefit*. The resulting figure is *Your Net LTD Monthly Benefit*.

If a benefit is payable for less than one month, it will be paid on the basis of 1/30th of the *Net LTD Monthly Benefit* for each day of *Disability*.
CDI-17AB

How do We *define Earnings?*

For salaried employees, *Monthly Earnings* equal the greater of your monthly basic salary rate as of September 1st of the calendar year prior to the plan year or your current monthly earnings *You* were receiving from *Your* Employer on the *Date of Disability*. It includes:

1) employee contributions made through a salary reduction agreement with *Your* Employer to an IRC Section 401(k), 403(b),457 deferred compensation plan, or any other qualified or non-qualified employee *Retirement Plan* or deferred compensation arrangement; and
2) amounts contributed to *Your* fringe benefits according to a salary reduction arrangement under an IRC Section 125 plan.

It does not include:

1) commissions;
2) bonuses;
3) overtime pay/shift differential;
4) *Your* Employer's contribution on *Your* behalf to a *Retirement Plan* or deferred compensation arrangement; or any other extra compensation.

For hourly employees, *Monthly Earnings* will equal the greater of *your* rate of record *You* were receiving from *Your* Employer on the *Date of Disability* or the basic hourly rate as of September 1st of the calendar year prior to the plan year. It includes:

1) employee contributions made through a salary reduction agreement with *Your* Employer to an IRC Section 401(k), 403(b), 457 deferred compensation plan, or any other qualified or non-qualified employee *Retirement Plan* or deferred compensation arrangement; and
2) amounts contributed to *Your* fringe benefits according to a salary reduction arrangement under an IRC Section 125 plan.

It does not include:

1) commissions;
2) bonuses;

3) overtime pay/shift differential;
4) *Your* Employer's contribution on *Your* behalf to a *Retirement Plan* or deferred compensation arrangement; or any other extra compensation.

CDI-19AA

What are the Deductible Sources of Income?

1) *Disability* benefits paid, payable, or for which there is a right under:
    a) The Social Security Act, including any amounts for which *Your* dependents may qualify because of *Your Disability*;
    b) Any Workers Compensation or Occupational Disease Act or Law, or any other law which provides compensation for an occupational *Injury* or *Sickness*;
    c) Occupational accident coverage provided by or through the Employer;
    d) Any Statutory Disability Benefit Law;
    e) The Railroad Retirement Act;
    f) The Canada Pension Plan, Quebec Pension Plan, or any other similar disability or pension plan or act;
    g) The Canada Old Age Security Act;
    h) Any Public Employee Retirement System Plan, or any State Teachers' Retirement System Plan, or any plan provided as an alternative to any of the above acts or plans.
2) *Disability* benefits paid under:
    a) Any group insurance plan provided by or through the Employer, and
    b) Any sick leave or salary continuance plan provided by or through the Employer.
3) Retirement benefits paid under the Social Security Act including any amounts for which *Your* dependents may qualify because of *Your* retirement;
4) Retirement and *Disability* benefits paid under a Retirement Plan provided by the Employer except for amounts attributable to *Your* contributions;
5) *Disability* benefits paid under any No Fault Auto Motor Vehicle coverage.

Proration of Lump Sum Awards

If any benefit described above is paid in a single sum through compromise settlement or as an advance on future liability, *We* will determine the amount of reduction to *Your Gross LTD Monthly Benefit* as follows:

1) *We* will divide the amount paid by the number of months for which the settlement or advance was provided; or
2) If the number of months for which the settlement or advance is made is not known, *We* will divide the amount of the settlement or advance by the expected remaining number of months for which *We* will provide benefits for *Your Disability* based on the Proof of *Disability* which *We* have, subject to a maximum of 60 months.

CDI-20AB

What other sources of income are not deductible?

We will not reduce *Your Gross LTD Monthly Benefit* by any of the following:

1) deferred compensation arrangements such as 401(k), 403(b) or 457 plans;
2) credit *Disability* insurance;
3) pension plans for partners;
4) military pension and *Disability* income plans;
5) franchise *Disability* income plans;
6) individual *Disability* income plans;
7) a *Retirement Plan* from another Employer;
8) profit sharing plans;
9) thrift or savings plans;
10) individual retirement account (IRA);

11) tax sheltered annuity (TSA);
12) stock ownership plan.

CDI-21AB

Can You work and still receive benefits?

While *Disabled, You* may qualify for the Work Incentive Benefit.

CDI-22AA

Work Incentive Benefit

A Work Incentive Benefit will be provided if *You* are *Disabled* and *Gainfully Employed* after the end of the *Elimination Period,* or after a period during which *You* received *LTD Monthly Benefits*.

The Work Incentive Benefit will be calculated during the first 12 months of *Gainful Employment* as follows:

1) The *Net LTD Monthly Benefit* amount and *Disability Earnings* amount will be added together and compared to *Monthly Earnings*.
2) If the total amount in Item 1 exceeds 100% of *Monthly Earnings*, the Work Incentive Benefit amount will be equal to the *Net LTD Monthly Benefit* reduced by the amount of the excess.
3) If the total amount in Item 1 does not exceed 100% of *Monthly Earnings*, the Work Incentive Benefit will be equal to the *Net LTD Monthly Benefit* amount.

After the first 12 months of *Gainful Employment*, the Work Incentive Benefit will be equal to the *Net LTD Monthly Benefit* amount less 50% of *Disability Earnings*.

The Work Incentive Benefit will cease on the earliest of the following:

1) the date *You* are no longer *Disabled;* or
2) the end of the *Maximum Period Payable*.

CDI-23AB

What is the minimum Net Long Term Disability Benefit payable under this program?

The *Net Long Term Disability Monthly Benefit* payable for *Disability* will not be less than $150. The minimum *Net Long Term Disability Monthly Benefit* does not apply if *You* are *Gainfully Employed.*

CDI-25AB

What happens if Your other benefits increase?

The *Net LTD Monthly Benefit* will not be further reduced for subsequent cost-of-living increases which are paid, payable, or for which there is a right under any Deductible Source of Income shown above.

CDI-26AB

How long will You receive benefits under this program?

We will send *You* a payment for each month of *Disability* up to the *Maximum Period Payable* as shown in the *Schedule of Benefits.* Payment of benefits is also subject to any benefit duration limitation pertaining to *Your Disability*.

CDI-27AB

What happens if Your Disability recurs?

If *Disability* for which benefits were payable ends but recurs due to the same or related causes less than 6 months after the end of a prior *Disability*, it will be considered a resumption of the prior *Disability*. Such recurrent *Disability* shall be subject to the provisions of the Policy that were in effect at the time the prior *Disability* began.

Disability which recurs more than 6 months after the end of a prior *Disability* are subject to:

1) a new *Elimination Period*;
2) a new *Maximum Period Payable*; and
3) the other provisions of the Policy that are in effect on the date the *Disability* recurs.

Disability must recur while *Your* coverage is in force under the Policy.

CDI-28AA

EXCLUSIONS AND LIMITATIONS

What are the exclusions and limitations under this program?

The Policy does not cover any loss caused by, contributed to, or resulting from:
CDIX-1AA

- declared or undeclared war or an act of either;
CDIX-2AA

- a *Pre-existing Condition*;
CDIX-4AA

- attempted suicide, while sane or insane, or intentional self-inflicted *Injury* or *Sickness*;
CDIX-5AA

- commission of or attempt to commit an act which is a felony in the jurisdiction in which the act occurred;
CDIX-6AA

- *Disability* beyond 24 months after the *Elimination Period* if it is due to mental or emotional disorders without demonstrable organic origin. Confinement in a *Hospital* or institution licensed to provide care and treatment for mental or emotional disorders will not be counted as part of the 24-month limit.
CDIX-3AA37

Benefits are not payable for any period during which *You* are confined to a penal or correctional institution if the period of confinement exceeds 30 days.
CDIX-12AA

TERMINATION OF COVERAGE

When will Your insurance terminate?

Your coverage will terminate on the earliest of the following dates:

1) the date the Policy is terminated; or
2) the date at the end of the period for which premium has been paid, subject to the Grace Period, if the Employer fails to pay the required premium for *You*, except for an inadvertent error; or
3) the date *You*:
    a) are no longer a member of a class eligible for this insurance, or
    b) withdraw from the program, or
    c) are retired or pensioned, or
    d) cease work because of a leave of absence, furlough, layoff, or temporary work stoppage due to a labor dispute, unless *We* and the Employer have agreed in writing in advance of the leave to continue insurance during such period.

Termination will not affect a covered loss which began before the date of termination.
CDI-30AB37

Will coverage be continued if You are eligible for leave under FMLA?

In the event *You* are eligible for and *Your* Employer approves a leave under the Family and Medical Leave Act of 1993 (FMLA), *Your* insurance will continue for a period of up to 12 weeks following the date the leave begins, provided the required premium continues to be paid.

You are eligible for leave under this Act in order to provide care:

1) After the birth of a child; or
2) After the legal adoption of a child; or
3) After the placement of a foster child in *Your* home; or
4) To a *Spouse*, child or parent due to their serious illness; or
5) For *Your* own serious health condition.

While granted a Family or Medical Leave of Absence:

1) The Employer must remit the required premium according to the terms of the policy; and

2) Coverage will terminate if *You* do not return to work as scheduled according to the terms of *Your* agreement with the Employer.

CDI-31AB

SUPPLEMENTAL BENEFITS AND SERVICES

CATASTROPHIC DISABILITY BENEFIT

(Applicable to the 60% Option Only)

When will You be eligible to receive a Catastrophic Disability Benefit?

We will pay a monthly *Catastrophic Disability* Benefit to *You* if *You* are receiving *LTD Monthly Benefits* and *We* receive proof that *You* are *Catastrophically Disabled*. *Catastrophic Disability* Benefits will begin at the end of the *Catastrophic Disability* Elimination Period shown in the *Schedule of Benefits*.

You are *Catastrophically Disabled* when *We* determine that, due to *Sickness* or *Injury*:

1) *You* are unable to perform, without human assistance or regular supervision from another person, at least 2 of the 6 *Activities of Daily Living*; or
2) a deterioration in *Your* intellectual capacity which requires substantial supervision of *You* by another person because *You* engage in behavior which poses a health or safety hazard to *You* or to others; and
3) *You* are not *Gainfully Employed*.

When will Your coverage become effective?

You will become insured for *Catastrophic Disability* Benefit coverage on *Your* effective date under the *LTD* plan.

However, the *Catastrophic Disability* Benefit coverage will be delayed if, on *Your* effective date, *You* cannot safely and completely perform one or more of the *Activities of Daily Living* without another person's assistance, or verbal cueing, or *You* have a deterioration or loss in intellectual capacity and need another person's assistance or verbal cueing for *Your* protection, or for the protection of others. Coverage will begin on the date *You* can safely and completely perform all of the *Activities of Daily Living* without another person's assistance or verbal cueing, or no longer have a deterioration or loss in intellectual capacity, and do not need another person's assistance or verbal cueing for *Your* protection, or for the protection of others.

How much will We pay if You are Disabled?

The *Catastrophic Disability* Benefit is 20% of *Monthly Earnings* to a maximum *Catastrophic Disability* Benefit of the lesser of the *LTD* plan maximum *Monthly Benefit* or $5,000.

This benefit is not subject to Policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income.

When will Your Catastrophic Disability Benefits end?

Catastrophic Disability Benefit payments will end on the earliest of the following dates:

1) the date *You* are no longer *Catastrophically Disabled*;
2) the date *You* become ineligible for *LTD Monthly Benefit* payments; or
3) the end of the *Catastrophic Disability Maximum Period Payable* shown in the *Schedule of Benefits*.

What claim information is needed for Catastrophic Disability Benefits?

The Claim Filing Requirements section under the Policy applies to *Catastrophic Disability* Benefit coverage. *We* may also require an interview with *You*.

CDIO-5AB

CLAIM SERVICES

What other services are available to You while You are Disabled?

If *You* are *Disabled* and eligible to receive *Disability* benefits under the Policy, *We* will evaluate *You* for eligibility to receive any of the following. *We* will make the final determination of your eligibility for any of the following benefits or services.

Worksite Modification Benefit

We will assist *You* and *Your* Employer in identifying modifications *We* agree are likely to help *You* remain at work or return to work. This agreement will be in writing and must be signed by *You*, *Your* Employer and *Us*.

When this occurs, *We* will reimburse *Your* Employer for the cost of the modification, up to the greater of:

1) $1,500; or
2) 2 months of *Your Net LTD Monthly Benefit*.

Vocational Rehabilitation Service

Rehabilitation services are available when *We* determine that these services are reasonably required to assist in returning *You* to *Gainful Employment*. Vocational rehabilitation services might include one or more of the following:

1) job modification;
2) job retraining;
3) job placement;
4) other activities.

Eligibility for vocational rehabilitation services is based upon *Your* education, training, work experience and physical and/or mental capacity. To be considered for rehabilitation services:

1) *Your* Disability must prevent *You* from performing *Your Regular Occupation*;
2) *You* must have the physical and/or mental capacities necessary for successful completion of a rehabilitation program, and
3) There must be a reasonable expectation that rehabilitation services will help *You* return to *Gainful Employment*.

Social Security Assistance

When necessary, *We* will provide an advocate for *You*, in applying for and securing Social Security *Disability* awards. When *We* determine that Social Security Assistance is appropriate for *You*, it is provided at no additional cost to *You*.

CDI-35AB

FILING A CLAIM

What are the Claim Filing Requirements?

Initial Notice of Claim

We ask that *You* notify *Us* of *Your* claim as soon as possible, so that *We* may make a timely decision on *Your* claim. The Employer can assist *You* with the appropriate telephone number and address of *Our* Claim Department. *You* must send *Us* written notice of *Your Disability* within 30 days of the *Date of Disability*, or as soon as reasonably possible. Notice may be sent to *Our* Claim Department, the CNA Home Office, CNA Plaza, Chicago, Illinois 60685 or given to *Our* Agent.

Written Proof of Loss

Within 15 days of *Our* being notified in writing of *Your* claim, *We* will supply *You* with the necessary claim forms. The claim form is to be completed and signed by *You*, the Employer and *Your Doctor*. If *You* do not receive the appropriate claim forms within 15 days, then *You* will be considered to have met the requirements for written proof of loss if *We* receive written proof, which describes the occurrence, extent and nature of loss as stated in the Proof of *Disability* provision.

Time Limit for Filing *Your* Claim

You must furnish *Us* with written proof of loss within 90 days after the end of *Your Elimination Period*. The length of the *Elimination Period* is stated in the *Schedule of Benefits*. If it is not possible to give *Us* written proof within 90 days, the claim is not affected if the proof is given as soon as possible. However, unless *You* are legally incapacitated, written proof of loss must be given no later than 1 year after the time proof is otherwise due.

No benefits are payable for claims submitted more than 1 year after the time proof is due. However, *You* can request that benefits be paid for late claims if *You* can show that:

1) It was not reasonably possible to give written proof during the 1 year period, and
2) Proof of loss satisfactory to *Us* was given as soon as was reasonably possible.

Proof of *Disability*

The following items, supplied at *Your* expense, must be a part of *Your* proof of loss. Failure to do so may delay, suspend or terminate *Your* benefits.

1) The date *Your Disability* began;
2) The cause of *Your Disability*;
3) The prognosis of *Your Disability*;
4) Proof that *You* are receiving *Appropriate and Regular Care* for *Your* condition from a *Doctor*, who is someone other than *You* or a member of *Your* immediate family, whose specialty or expertise is the most appropriate for *Your* disabling condition(s) according to *Generally Accepted Medical Practice*.
5) Objective medical findings which support *Your Disability*. Objective medical findings include but are not limited to tests, procedures, or clinical examinations standardly accepted in the practice of medicine, for *Your* disabling condition(s).
6) The extent of *Your Disability*, including restrictions and limitations which are preventing *You* from performing *Your Regular Occupation*.
7) Appropriate documentation of *Your Monthly Earnings*. If applicable, regular monthly documentation of *Your Disability Earnings*.
8) If *You* were contributing to the premium cost, *Your* Employer must supply proof of *Your* appropriate payroll deductions.
9) The name and address of any *Hospital* or *Health Care Facility* where *You* have been treated for *Your Disability*.

Continuing Proof of *Disability*

You may be asked to submit proof that *You* continue to be *Disabled* and are continuing to receive *Appropriate and Regular Care* of a *Doctor*. Requests of this nature will only be as often as *We* feel reasonably necessary. If so, this will be at *Your* expense and must be received within 30 days of *Our* request. Failure to do so may delay, suspend or terminate *Your* benefits.

Examination

At *Our* expense, *We* have the right to have *You* examined as often as reasonably necessary while the claim continues. Failure to comply with this examination may deny, suspend or terminate benefits, unless *We* agree *You* have a valid and acceptable reason for not complying.

Authorization and Documentation *You* will be asked to supply

1) *You* will be required to provide signed authorization for *Us* to obtain and release all reasonably necessary medical, financial or other non-medical information which support *Your Disability* claim. Failure to submit this information may deny, suspend or terminate *Your* benefits.
2) *You* will be required to supply proof that *You* have applied for other Deductible Income Benefits such as Workers' Compensation or Social Security *Disability* benefits, when applicable.
3) *You* will be required to notify *Us* when *You* receive or are awarded other Deductible Income Benefits. *You* must tell *Us* the nature of the income benefit, the amount received, the period to which the benefit applies, and the duration of the benefit if it is being paid in installments.

CDI-36AB

Time of Payment of Claim

As soon as *We* have all necessary substantiating documentation for *Your Disability* claim, *Your* benefit will be paid on a monthly basis, so long as *You* continue to qualify for it.

We will pay benefits to *You* unless otherwise indicated. If *You* die while *Your* claim is open, any due and unpaid *Disability* benefit will be paid to *Your* named beneficiary, if any.

If there is no surviving beneficiary, payment may be made, at *Our* option, to the surviving person or persons in the first of the following classes of successive preference beneficiaries: *Your*: 1) *Spouse*; 2) children including legally adopted children; 3) parents; 4) brothers or sisters; or 5) estate.

If any benefit is payable to an estate, a minor or a person not competent to give a valid release, *We* may pay up to $1,000 to any relative or beneficiary of *Yours* whom *We* deem to be entitled to this amount. *We* will be discharged to the extent of such payment made by *Us* in good faith.
CDI-37AB

Can you assign Your benefits?

Your benefits are not assignable, which means that *You* may not transfer *Your* benefits to anyone else.
CDI-38AA

What will happen if a claim is overpaid?

A claim overpayment can occur when *You* receive a retroactive payment from a Deductible Source of Income; when *We* inadvertently make an error in the calculation of *Your* claim; or if fraud occurs.

In an overpayment situation, *We* will determine the method by which the repayment is made. *You* will be required to sign an agreement with *Us* which details the source of the overpayment, the total amount *We* will recover and the method of recovery. If *LTD Monthly Benefits* are suspended while recovery of the overpayment is being made, suspension will also apply to the minimum *LTD Monthly Benefits* payable under the Policy.

The overpayment amount equals the amount *We* paid in excess of the amount *We* should have paid under the Policy.
CDI-39AA

Subrogation – Right of Reimbursement

When any claim payment is made, *We* reserve any and all rights to subrogation and/or reimbursement to the fullest extent allowed by statute and customary practice. Any party to this contract shall not perform any act that will prejudice such rights without prior agreement with *Us*.

We will bear any expenses associated with *Our* pursuit of subrogation or recovery.
CDI-41AA

Fraud

Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and may subject such person to criminal and civil penalties. Such penalties include, but are not limited to fines, denial or termination of insurance benefits, recovery of any amounts paid, civil damages, criminal prosecution and confinement in state prison.
CDI-42AA

UNIFORM PROVISIONS

Entire Contract; Changes

The Policy, the Employer's application, the employee's certificate of coverage, and *Your* application, if any, and any other attached papers, form the entire contract between the parties. Coverage under the Policy can be amended by mutual consent between the Employer and *Us*. No change in the Policy is valid unless approved in writing by one of *Our* officers. No agent has the right to change the Policy or to waive any of its provisions.

Statements on the Application

Any statement made by the Employer or *You*, except for fraudulent misstatements, is considered a representation and not a warranty. No such statement shall void the insurance, reduce the benefits or be used in defense to a claim unless it is in writing signed by the Employer or *You* and a copy furnished to the Employer or *You* or *Your* beneficiary, whoever made the statement. No statement of the Employer will be used to void the Policy after it has been in force for 2 years. No statement of *Yours* will be used in defense of a claim after *You* have been insured for 2 years, except for fraudulent misstatements.

Legal Actions

No legal action of any kind may be filed against *Us* :

1) within the 60 days after proof of *Disability* has been given; or
2) more than 3 years after proof of *Disability* must be filed, unless the law in the state where *You* live allows a longer period of time.

Conformity with State Statutes

If any provision of the Policy conflicts with the statutes of the state in which the policy was issued or delivered, it is automatically changed to meet the minimum requirements of the statute.
CDI-40AB37

General Provisions

We have the right to inspect all of the Employer's records on the Policy at any reasonable time. This right will extend until:

1) 2 years after termination of the Policy; or
2) all claims under the Policy have been settled,

whichever is later

The Policy is in the Employer's possession and may be inspected by *You* at any time during normal business hours at the Employer's office.

The Policy is not in lieu of and does not affect any requirements for coverage by Workers' Compensation Insurance.
CDI-43AB

DEFINITIONS

The following are key words and phrases used in this certificate. When these words and phrases, or forms of them, are used, they are capitalized and italicized in the text. As *You* read this certificate, refer back to these definitions.

Actively at Work or ***Active Work*** means that *You* must be:

1) working at the Employer's usual place of business, or on assignment for the purpose of furthering the Employer's business; and
2) performing the *Material and Substantial Duties* of *Your Regular Occupation* on a full-time basis.

CDID-1AB

Activities of Daily Living means:

1) Eating – Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
2) Toileting – Getting to and from the toilet, getting on and off the toilet and performing associated personal hygiene.
3) Transferring – Moving into or out of a bed, chair or wheelchair.
4) Bathing – Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
5) Dressing – Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
6) Continence – Ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

CDID-2AA

Appropriate and Regular Care means that *You* are regularly visiting a *Doctor* as frequently as medically required to meet *Your* basic health needs. The effect of the care should be of demonstrable medical value for *Your* disabling condition(s) to effectively attain and/or maintain *Maximum Medical Improvement*.

CDID-4AA

Date of Disability is the date *We* determine *Your Injury* or *Sickness* impairs *Your* ability to perform *Your Regular Job*.

CDID-5AA

Disability or ***Disabled*** means that *You* satisfy either the Occupation Qualifier or the Earnings Qualifier.

CDID-6AA

Disability Earnings is the wage or salary *You* earn from *Gainful Employment* after a *Disability* begins. It includes partnership or proprietorship draw, commissions, bonuses, or similar pay, and any other income *You* receive or are entitled to receive. It does not include Social Security, sick pay, salary continuance payments or any other *Disability* payment *You* receive as a result of *Your Disability*. Any lump sum payment will be prorated, based on the time over which it accrued or the period for which it was paid.

CDID-7AB

Doctor means a person legally licensed to practice medicine, psychiatry, psychology or psychotherapy, who is neither *You* nor a member of *Your* immediate family. A licensed medical practitioner is a *Doctor* if applicable state law requires that such practitioners be recognized for purposes of certification of *Disability*, and the treatment provided by the practitioner is within the scope of his or her license.

CDID-8AA

Elimination Period means the number of calendar days at the beginning of a continuous period of *Disability* for which no benefits are payable. The *Elimination Period* is shown in the *Schedule of Benefits*.

CDID-9AA

Gainful Employment or ***Gainfully Employed*** means the performance of any occupation for wages, remuneration or profit, for which *You* are qualified by education, training or experience on a full-time or part-time basis, for the Employer or another employer, and which *We* approve and for which *We* reserve the right to modify approval in the future.
CDID-10AA

Generally Accepted Medical Practice or ***Generally Accepted in the Practice of Medicine*** means care and treatment which is consistent with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies.
CDID-11AA

Gross LTD Monthly Benefit means that benefit shown in the *Schedule of Benefits* which applies to *You*.
CDID-20AGross

Hospital or Health Care Facility is a legally operated, accredited facility licensed to provide full-time care and treatment for the condition(s) causing *Your Disability*. It is operated by a full-time staff of licensed physicians and registered nurses. It does not include facilities which primarily provide custodial, educational or rehabilitative care.
CDID-12AA

Injury means bodily injury caused by an accident which results, directly and independently of all other causes, in *Disability* which begins while *Your* coverage is in force.
CDID-13AA

Insured Employee means an employee whose insurance is in force under the terms of the Policy.
CDID-14AA

LTD means Long Term Disability.
CDID-35AA

Male pronoun, whenever used, includes the female.
CDID-16AA

Material and Substantial Duties means the necessary functions of *Your Regular Job* which cannot be reasonably omitted or altered.
CDID-17AA

Maximum Medical Improvement is the level at which, based on reasonable medical probability, further material recovery from, or lasting improvement to, an *Injury* or *Sickness* can no longer be reasonably anticipated.
CDID-18AA

Maximum Period Payable, as shown in the *Schedule of Benefits*, means the longest period of time that *We* will make payments to *You* for any one period of *Disability*.
CDID-32AA

Mental Disorder means a disorder found in the current diagnostic standards of the American Psychiatric Association.
CDID-19AA

Monthly Benefit means that benefit shown in the *Schedule of Benefits* which applies to *You*.
CDID-20AA

Net LTD Monthly Benefit means the *Gross Long Term Disability Monthly Benefit* less the Deductible Sources of Income.
CDID-20ANet

Pre-existing Condition means a condition for which medical treatment or advice was rendered, prescribed or recommended within 90 days prior to *Your* effective date of insurance. A condition shall no longer be considered pre-existing if it causes *Disability* which begins after *You* have been insured under the Policy for a period of 12 months.
CDID-21BA37

Regular Job means the occupation that *You* are performing for income or wages on *Your Date of Disability*. It is not limited to the specific position *You* held with *Your* Employer.
CDID-22BA

Retirement Plan means a plan which provides retirement benefits to employees and is not funded wholly by employee contributions.
CDID-24AA

Schedule of Benefits means the schedule which is a part of this certificate.
CDID-28AA

Sickness means sickness or disease causing *Disability* which begins while *Your* coverage is in force.
CDID-26AA

We, ***Our*** and ***Us*** mean the CNA Group Life Assurance Company, Chicago, Illinois.
CDID-29AA

You, ***Your*** and ***Yours*** means the employee to whom this certificate is issued and whose insurance is in force under the terms of the Policy.
CDID-30AA

IMPORTANT ERISA WELFARE PLAN INFORMATION

The following section contains information provided to You at the request of the Plan Administrator of Your Plan to meet certain requirements of the Employee Retirement Income Security Act of 1974, as amended, (ERISA). All inquiries related to the following material should be referred directly to Your Plan Administrator.

DISCRETIONARY AUTHORITY

The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments thereto. The Plan Administrator and other plan fiduciaries have discretionary authority to determine Your eligibility to participate in the Westinghouse Electric Company Welfare Benefits Plan. The Plan Administrator has delegated sole discretionary authority to CNA Group Life Assurance Company to determine Your eligibility for benefits as it relates to Disability and to interpret the terms and provisions of the Plan and any policy issued in connection with it.

SUMMARY PLAN DESCRIPTION (SPD) AND ERISA STATEMENT OF RIGHTS

The following sections contain information provided to You by the Plan Administrator of Your Plan to meet the requirements of the Employee Retirement Income Security Act of 1974, as amended. It does not constitute a part of the Plan, nor of any insurance policy issued in connection with it. All inquiries relating to the following material should be referred directly to Your Plan Administrator.

SUMMARY PLAN DESCRIPTION

Name of Plan

The plan for which this Summary Plan Description is provided is known as the Westinghouse Government Services Company, LLC Group Disability Income Insurance Plan, herein referred to as the "Plan".

Maintenance of Plan

The Plan is maintained by:

Employer Identification Number and Plan Number

The Employer identification number (EIN) assigned by the Internal Revenue Service to the Plan Sponsor is 52-2140933.

The Plan Number assigned by the Plan sponsor is 501.

Type of Welfare Plan

The Plan is a group disability income insurance plan.

Administration of Plan

The Plan is administered by the Plan Administrator through an insurance contract purchased from CNA Group Life Assurance Company. Certain ministerial functions are performed on behalf of the Plan by CNA Group Life Assurance Company. These functions include, but are not limited to, administration and payment of claims, determination of Your eligibility under the Plan, premium billing and policy and certificate issuance.

Plan Sponsor/Administrator *(Herein referred to as the Administrator)*

Telephone Number: (412) 374-2257

The Administrator and other Plan fiduciaries have discretionary authority to interpret the terms of the Plan and to determine Your eligibility for and entitlement to benefits in accordance with the Plan. With respect to making benefit decisions, the Plan Administrator has delegated sole discretionary authority to CNA Group Life Assurance Company to determine Your eligibility for and entitlement to benefits under the Plan and to interpret the terms and provisions of any insurance policy issued in connection with the Plan.

Agent for Service of Legal Process

The person designated as agent for service of legal process upon the Plan is:

In addition, service of process may be made upon the Administrator.

Eligibility and Benefits

The Plan's requirements respecting eligibility for participation, the conditions pertaining to eligibility to receive benefits and a description or summary of the benefits are listed in the certificate portion of this booklet.

Circumstances Which May Affect Benefits

Circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of any benefits are listed in the certificate portion of this booklet.

The Plan Administrator reserves the right to modify, amend, or terminate the Plan in whole or in part. Such right may be exercised at any time and at the Plan Administrator's sole discretion.

Right of Recovery Due to Benefit Overpayment

If, for any reason, a benefit is paid under the Plan which is larger than the amount allowed in accordance with the Plan, the Plan reserves the right to recover the excess amount from the person or agency that received such overpayment.

Sources of Plan Contributions

Contributions to the Plan are made by the employer.

Medium for Providing Benefits

Benefits under the Plan are provided in accordance with the provisions of Group Insurance Policy Number SR-83115804 issued by CNA Group Life Assurance Company, CNA Plaza, Chicago, Illinois 60685. Benefits available under the Plan are not guaranteed under the Group Insurance Policy.

Date of End of Plan's Fiscal Year

The date of the end of each year for purposes of maintaining the Plan's fiscal records is DECEMBER 31.

Claim Procedures

1) **Presenting Claims for Benefits**

   Claim forms may be obtained from: Employer.

   Please see Your insurance certificate or booklet for the requirements of the Group Insurance Policy as to notice of claims.

   The insurance company will provide notice of benefit determination no later than 45 days after receipt of the claim. This period may be extended by 30 days if it is determined that matters beyond the control of the plan make such an extension necessary. You will receive written notification of the extension and the date by which the insurance company expects to decide your claim prior to the end of the initial 45-day period. If, prior to the end of the 30-day extension period, it is determined that a decision cannot be made due to matters beyond the control of the plan, the period for making the decision may be extended for up to an additional 30 days. You will be notified in writing of the additional extension and the date by which the insurance company expects to decide your claim prior to the end of the initial 30-day extension period. Each notice of extension will explain the standards on which entitlement to benefits is based, the reasons for the delay, and the additional information needed to make a decision on the claim. If the extension is due to your failure to submit information necessary to decide the claim, the time limitations for the insurance company will be tolled from the date the notification of the extension is sent until the date you respond to the request for additional information. You will have 45 days within which to provide the necessary information.

2) **Claims Denial Procedure**

   Any denial of a claim for benefits will be provided by the insurance company and consist of a written explanation which will include:

   i) the specific reasons for the denial;
   ii) reference to the pertinent plan provisions upon which the denial is based;
   iii) a description of any additional information You might be required to provide and explanation of why it is needed; and
   iv) an explanation of the Plan's claim review procedure.

   You, Your beneficiary (when an appropriate claimant), or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a full and fair review to the insurance company. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed, and comments and issues outlining the basis of the appeal may be submitted in writing. You may have representation throughout the review procedure. A request for a review must be filed by 180 days after receipt of the written notice of denial of a claim. The full and fair review will be held and a decision rendered by the insurance company no longer than 45 days after receipt of the request for the review.

   If there are special circumstances, the decision will be made as soon as possible, but not later than 90 days after receipt of the request for the review. If such an extension of time is needed, You will be notified in writing prior to the beginning of the time extension period. The decision after Your review will be in

writing and will include specific reasons for the decision as well as specific references to the pertinent Plan provisions on which the decision is based.

ERISA AND EFFECT ON EMPLOYMENT

No one may fire You or otherwise discriminate against You in order to prevent You from obtaining a welfare benefit You are entitled to under the Plan or exercising Your rights under ERISA. However, nothing listed herein, or in any Plan document or insurance policy issued in connection with the Plan, shall be construed to say or imply that Your participation in the Plan is a guarantee of Your continued employment with Your Employer. Your employment status shall not be affected by Your participation in the Plan or exercise of Your rights under ERISA.

YOUR RIGHTS UNDER ERISA

As a participant in the above described Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to the following rights and protections under the law.

Receive Information About Your Plan and Benefits

As a participant in an ERISA covered Plan, You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your Employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

Enforce Your Rights

If Your claim for a welfare benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court. In addition, if You disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order you to pay these costs and fees, for example, if it finds Your claim is frivolous.

Assistance with Your Questions

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

IMPORTANT NOTICE FOR NON-ENGLISH SPEAKING EMPLOYEES

Para Empleados Que No Hablan Inglés

Este documento contiene un resumen en inglés de los derechos y beneficios que le corresponden bajo el plan de seguro de accidente grupal creado y mantenido por su empresa. Si tiene alguna pregunta acerca de la información contenida en el documento, communiquese con el Administrador para obtener ayuda. La dirección del Administrador es:

Numero de Teléfono: (412) 374-2257

Appendix I – How To Report a Disability

REPORTING A DISABILITY CLAIM

WHEN DO I REPORT A DISABILITY CLAIM?

You need to report a disability claim to Hartford Life within 7 days after your first absence from work. Ask your doctor to make a copy of the attached "Authorization to Release Information" form. Sign, date, and give the copy to your doctor to authorize your doctor to give the necessary information about your medical condition to the Hartford Life nurse.

If you know you're going to be out of work for a pre-scheduled absence (like a pregnancy) you can call up to 2 weeks in advance of your last day of work.

WHAT CAN I EXPECT WHILE I'M OUT ON DISABILITY?

Our goal is to help you get well and return to work as quickly and as safely as possible. While you are disabled, Hartford Life will assign a claim professional to you who will call you periodically to check on your progress and will discuss return to work possibilities that meet your functional limitations.

I'M READY TO COME BACK TO WORK – WHAT NOW?

GREAT! When you are ready to come back to work let your employer and your Hartford Life claim professional know that you are ready.

WELCOME BACK!

HOW DO I REPORT A DISABILITY CLAIM?

It's as easy as 1, 2, 3

1 Call ***1-800-303-9744***, Monday through Friday, 8:00am to 8:00pm, Eastern Time. Be prepared to provide your:

- Personal information, including your Social Security Number
- Your employer's name, supervisor's name, division, address and phone number
- Date of hire
- Last day worked prior to your illness or injury
- Physician's name, address and phone number
- A description of your illness or injury
- A description of your occupation

The Hartford Life nurse will take all the necessary information to file your claim and will make sure you understand key elements of your disability coverage, such as how long you must be disabled before your benefits begin and any factors that might limit benefit payment.

2 The nurse will contact your physician to obtain additional medical information necessary for Hartford Life to make a disability determination and will verify your eligibility.

3 When the Hartford Life disability team approves your claim, they will advise you of your benefit amount, the length of time you should be out of work and your expected return to work date. Hartford Life will also contact your employer.

Hartford Life and Accident Insurance Company Authorization to Release Information

Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, government agency, Social Security Administration, insurance company, group policyholder, employer or benefit plan administrator designated on the attached or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, to provide to the Company designated above information concerning medical diagnosis, advice, care or treatment provided to the individual named below, including information related to mental illness (except psychotherapy notes), H.I.V., use of drugs or use of alcohol. I also authorize my employer, group policyholder or benefit plan administrator to provide the Company designated above with financial or employment-related information. I understand that such information is disclosed at my request and will be collected by the Company designated above for purposes of evaluating my claim for insurance benefits.

I UNDERSTAND that the Company may provide only the above-referenced financial or employment related information to my employer through the appropriate employee benefit/human resources coordinators.

I UNDERSTAND the Company may, upon request by a state department of insurance, department of labor, workers' compensation board, or other regulatory body with authority or jurisdiction over the claim, provide any information requested by these or similar entities. Additionally, in the event that I file a Workers' Compensation claim, I authorize the Company to redisclose the above information to the Workers' Compensation carrier.

I UNDERSTAND the Company may condition eligibility for benefits on my signature on this authorization. I UNDERSTAND that information disclosed pursuant to this Authorization may be subject to redisclosure and no longer the responsibility of the provider of information to the Company. I UNDERSTAND that I may revoke this Authorization at any time by providing written notice to the Company, except to the extent that an individual has taken action in reliance upon such authorization prior to notice of the revocation. I UNDERSTAND that if I exercise my right to revoke this authorization during the duration of the claim, the Company may deny my claim.

I UNDERSTAND that I may request a copy of this Authorization. This authorization is valid from the date signed for the duration of the claim. I agree that a photographic copy of this authorization shall be as valid as the original.

Employee's Printed Name:	**Name of Employee's Representative (if necessary):**
Signature of Employee or Employee's Representative:	**Date Signed:**

To Report a Claim

1. Call your manager to report your first day of absence from work.
2. See your medical provider. Bring this card.

   Have the provider make a copy of the release on the other side of this card.

   Sign and date the copy for the provider's files.

   Prompt and complete information from you and your physician will help prevent delays in any benefit payment for which you may be eligible.
3. Call Hartford Life at **1-800-303-9744** within 7 days after your first absence from work to begin the claim process.

CALL

1-800-303-9744

Monday – Friday, 8:00am – 8:00pm ET

TO REPORT A NEW DISABILITY CLAIM

Important Information regarding the disability coverage provided by Westinghouse

Please read carefully

and

Keep for Future Reference

National Account Service Center

Disability Claims

PO Box 946710

Maitland, FL 32794-6710

1-800-303-9744

Monday – Friday, 8:00 am to 8:00 pm ET

Disability insurance from Hartford Life is underwritten by Hartford Life and Accident Insurance Company. Hartford Life is a registered service mark. This brochure is for illustrative purposes only and is not a contract. It is intended to provide a general overview of the services described. Remember that only the insurance policy can give actual terms, coverage and amounts, conditions and exclusions.

Appendix J – Employee Cost of Coverage in 2004

Medical Coverage

You and the Company share the cost of Medical coverage.

Medical Coverage for Full-Time Employees:

	Employee Only	Employee + 1 Dependent	Employee + 2 or more Dependents
Premium PPO	1.155% of Benefit Pay	2.310% of Benefit Pay	3.465% of Benefit Pay
Standard PPO	0.525% of Benefit Pay	1.050% of Benefit Pay	1.575% of Benefit Pay
Comprehensive Out-of-Area	1.155% of Benefit Pay	2.310% of Benefit Pay	3.465% of Benefit Pay

Note: Benefit Pay is capped at $140,000 before calculating employee prices.

Medical Coverage for Part-Time Employees:

	Employee Only	Employee + 1 Dependent	Employee + 2 or more Dependents
Standard PPO	$130.81/month	$261.60/month	$392.41/month

Employees with 25 or more years of service and are laid-off or permanently separated, and their surviving spouses:

	Employee Only	Employee + 1 Dependent	Employee + 2 or more Dependents
Premium PPO	$140.44/month	$280.88/month	$421.32/month
Standard PPO	$130.81/month	$261.60/month	$392.41/month
Comprehensive Out-of-Area	$140.44/month	$280.88/month	$421.32/month

Survivor of a Full-Time Employee who met the age and service requirements*, after the first 12 months:

	Employee Only	Employee + 1 Dependent	Employee + 2 or more Dependents
Premium PPO	$70.22/month	$140.44/month	$210.66/month

Standard PPO	$65.40/month	$130.80/month	$196.20/month
Comprehensive Out-of-Area	$70.22/month	$140.44/month	$210.66/month

*Age and service requirements: At least age 50 with at least 15 years of Eligibility Service as of the date of death; at least age 60 with at least 10 years of Eligibility Service as of the date of death; or any age with at least 25 years of Eligibility Service as of the date of death.

Retiree Pre-Medicare Coverage

Employee Only	Employee + 1 Dependent	Employee + 2 or more Dependents
$17.00/month	$213.00/month	$258.00/month

Pre-Medicare Coverage for Survivors of Retirees

Employee Only	Employee + 1 Dependent	Employee + 2 or more Dependents
$105.82/month	$211.64/month	$264.54/month

Special Programs with Medicare (SPM)

You and the Company share the cost of Special Programs with Medicare (SPM).

SPM Coverage for Retirees

Employee Only	Employee + 1 Dependent
$18.00/month	$36.00/month

SPM Coverage for Survivors of Retirees

Employee Only
$13.37/month

Grandfathered Provision – Totally and Permanently Disabled: If you were certified by the insurance carrier as Totally and Permanently Disabled prior to 1/1/2000, you and your spouse will not be required to pay for SPM coverage.

Employees with 25 or more years of service and are laid off or permanently separated and their surviving spouses:

Employee Only	Employee + 1 Dependent
$26.74/month	$53.49/month

Dental Coverage

You and the Company share the cost of Dental coverage.

Dental Coverage (Full-Time, Part-Time):

	Employee Only	Employee + 1 Dependent	Employee + 2 or more Dependents
Premium PPO	$5.00/month	$10.00/month	$15.00/month
Standard PPO	$2.50/month	$5.00/month	$7.50/month

Pre-Medicare Coverage for Retirees

Employee Only	Employee + 1 Dependent	Employee + 2 or more Dependents
$5.00/month	$10.00/month	$15.00/month

Pre-Medicare Coverage for Survivors of Retirees

Employee Only	Employee + 1 Dependent	Employee + 2 or more Dependents
$5.36/month	$10.71/month	$16.07/month

Survivor of a Full-Time Employee who met the age and service requirements*, after the first 12 months:

	Employee Only	Employee + 1 Dependent	Employee + 2 or more Dependents
Premium PPO	$5.36/month	$10.71/month	$16.07/month
Standard PPO	$3.45/month	$6.90/month	$10.35/month

*Age and service requirements: At least age 50 with at least 15 years of Eligibility Service as of the date of death; at least age 60 with at least 10 years of Eligibility Service as of the date of death; or any age with at least 25 years of Eligibility Service as of the date of death.

Employee Assistance Program

Employer-paid

COBRA Continuation

Employee-paid

	Individual	Two Persons	Three or More Persons
Premium PPO Medical, Expatriate and Comprehensive Out-of-Area Medical Coverage	$286.49	$572.99	$859.48
Standard PPO Medical	$266.84	$533.66	$800.51
Pre-Medicare Medical Coverage	$431.74	$863.48	$1,079.33
Special Programs with Medicare (SPM)	$54.56	$109.12	N/A
Premium Dental PPO, Expatriate and Retiree Dental	$21.86	$43.71	$65.56
Standard Dental PPO	$14.09	$28.16	$42.24
Employee Assistance Program	$1.64	$1.64	$1.64

Accident & Sickness Benefit Coverage

Employer-paid

Long-Term Disability Benefit Coverage

You pay the full cost of Long-Term Disability Benefit Coverage.

Option 1: 60% of Benefit Pay	Option 2: 70% of Benefit Pay
.0049 x Benefit Pay	.0084 x Benefit Pay

Basic Life Insurance Coverage

Employer-paid

Basic AD&D Insurance Coverage

Employer-paid

Business Travel Accident Insurance Coverage

Employer-paid

Additional/Supplemental Life Insurance Coverage

Enrollment grandfathered as of December 31, 1991. Pricing is age based and is administered by MetLife. Below are the prices per $1,000 of coverage.

Under 30	$0.08
30-34	$0.09
35-39	$0.11
40-44	$0.17
45-49	$0.29
50 and over	$0.39

You and the Company share the cost of Additional/Supplemental Life Insurance Coverage.

Group Universal Life

Pricing is age-band rated and is administered by MetLife. Below are the prices per $1,000 of coverage.

Under 30	$0.05
30-34	$0.07
35-39	$0.08
40-44	$0.15
45-49	$0.31
50-54	$0.47
55-59	$0.79
60-64	$1.25
65-69	$1.85

You pay the full cost of Group Universal Life Insurance.

Dependent Life Insurance Coverage

You pay the full cost of Dependent Life Insurance Coverage.

Option 1: **$5,000 spouse; $1,000/child**	**Option 2:** **$10,000 spouse; $2,000/child**	**Option 3:** **$15,000 spouse; $3,000/child**	**Option 4:** **$20,000 spouse; $4,000/child**
$1.01/month	$2.02/month	$3.03/month	$4.04/month

Personal Accident Insurance Coverage for Yourself

$0.25/month per $10,000 increment

You pay the full cost of Personal Accident Insurance Coverage for yourself.

Personal Accident Insurance Coverage for Your Dependents

$0.35/month per $10,000 increment

You pay the full cost of Personal Accident Insurance Coverage for your dependents.

Health Care Spending Account

Your contributions

Day Care Spending Account

Your contributions

Long-Term Care Insurance Coverage

Age-based; see Appendix O

You pay the full cost of Long-Term Care Insurance Coverage.

Appendix K – Information About Plan Administrator, Network Administrators, Insurance Carriers, & Vendors

For Questions Regarding	Contact Information	Appeals Authority
	Plan Administrator: Administrative Committee of Westinghouse Government Services Group **Phone Number:** 412-374-3995 **Address:** Westinghouse Government Services Group 4350 Northern Pike, Room 217C Monroeville, PA 15146	
Eligibility • General benefits questions • Obtain help if you cannot make your change or find an answer to your question through the *Your Benefits Resources*™ Web site	**Administrator:** Westinghouse Benefits Center **Phone Number:** 1-800-890-3600 **Address:** 100 Half Day Road Lincolnshire, IL 60069 **Web site:** www.mybenefitsdirectory.com/westinghouse (Direct Web site: http://resources.hewitt.com/westinghouse)	**Appeals Authority** The Administrative Committee of Westinghouse Government Services Group Welfare Benefits Plan 4350 Northern Pike, Room 217C Monroeville, PA 15146-2886
Medical Coverage • Which medical services are covered or not covered, • Medical coverage Identification Cards, • Pre-certify an in-hospital admission, • Find a network provider, or • Any other detailed medical questions	**Network Administrator:** Highmark Blue Cross Blue Shield Group Numbers – Westinghouse Government Services Company, LLC: • Premium PPO: 46422 • Premium PPO (Western PA area): 46479 • Standard PPO: 46425 • Standard PPO (Western PA area): 46482 • Comprehensive Out-of-Area: 46428 Group Numbers – Westinghouse Government Environmental Services Company, LLC:	**Appeals Authority:** Highmark Blue Cross Blue Shield Member Grievance & Appeals PO Box 535095 Pittsburgh, PA 15253-5095 Attn: Review Committee

For Questions Regarding	Contact Information	Appeals Authority
	• Premium PPO: 46421 • Premium PPO (Western PA area): 46478 • Standard PPO: 46424 • Standard PPO (Western PA area): 46481 • Comprehensive Out-of-Area: 46427 **Phone Number:** 1-800-890-3600 (Direct Number: 1-888-227-7378) (Direct Number for Hospital Precertification: 1-800-452-8507) **Address:** Highmark Blue Cross Blue Shield Claims / Correspondence P.O. Box 1210 Pittsburgh, PA 15230-1210 **Web site:** www.mybenefitsdirectory.com/westinghouse (Direct Web site: www.highmarkbcbs.com)	
Mental Health and Substance Abuse Treatment Coverage • Which mental health and substance abuse treatment services are covered or not covered, • Certify mental health and substance abuse treatment; • Find a network provider, or • Any other detailed mental health and substance abuse treatment questions	**Network Administrator:** ValueOptions **Phone Number:** 1-800-890-3600 (Direct Number: 1-877-866-4911) **Address:** ValueOptions P.O. Box 1347 Latham, NY 12110-8847 **Web site for on-line library:** www.mybenefitsdirectory.com/westinghouse (Direct Web site: www.achievesolutions.net/westinghouse)	**Appeals Authority for Initial Appeal:** ValueOptions P.O. Box 1347 Latham, NY 12110-8847 Attn: Westinghouse Government Services Group Claims Services **Appeals Authority for Final Appeal:** The Administrative Committee of Westinghouse Government Services Group Welfare Benefits Plan 4350 Northern Pike, Room 217C Monroeville, PA 15146-2886

Prescription Drug Coverage • Which prescription drugs are covered or not covered, • Prescription drug Identification Cards, • Obtain a prior authorization, • Find a network provider, or • Any other detailed prescription drug questions	**Network Administrator:** Eckerd Health Services (EHS) **Phone Number:** 1-800-890-3600 (Direct Number: 1-877-347-7444) **Address:** EHS 620 Epsilon Drive Pittsburgh, PA 15238 **Web site:** www.mybenefitsdirectory.com/westinghouse (Direct Web site: www.ehs.com)	**Appeals Authority for Initial Appeal:** EHS 620 Epsilon Drive Pittsburgh, PA 15238 **Appeals Authority for Final Appeal:** The Administrative Committee of Westinghouse Government Services Group Welfare Benefits Plan 4350 Northern Pike, Room 217C Monroeville, PA 15146-2886
Vision Coverage • Which vision services are covered or not covered, • Find a network provider, or • Any other detailed vision questions	**Network Administrator:** Vision Service Plan (VSP) Contract Number: 12129888 **Phone Number:** 1-800-890-3600 (Direct Number: 1-800-877-7195) **Address:** Vision Service Plan (VSP) Attn: Out-of-Network Claims P.O. Box 997100 Sacramento, CA 95899-7100 **To obtain provider information:** **Web site:** www.mybenefitsdirectory.com/westinghouse (Direct Web site: www.vsp.com)	**Appeals Authority for Initial Appeal:** Vision Service Plan (VSP) Claims Department 3333 Quality Drive Rancho Cordova, CA 95670 **Appeals Authority for Final Appeal:** The Administrative Committee of Westinghouse Government Services Group Welfare Benefits Plan 4350 Northern Pike, Room 217C Monroeville, PA 15146-2886

Special Programs with Medicare (SPM) Coverage • Questions about SPM's Prescription Drug Program • Questions about SPM's Hospital Program	**SPM's Prescription Drug Program:** See above under Prescription Drug Coverage **SPM's Hospital Program Administrator:** HM Benefits Administrators, Inc. **Phone Number:** 1-800-890-3600 (Direct Number: 1-888-421-3273) **Address:** HM Benefits Administrators, Inc. P.O. Box 535052 Pittsburgh, PA 15253	**SPM's Prescription Drug Program:** See above under Prescription Drug Coverage **SPM's Hospital Program:** **Appeals Authority for Initial Appeal:** HM Benefits Administrators, Inc. P.O. Box 535052 Pittsburgh, PA 15253 **Appeals Authority for Final Appeal:** The Administrative Committee of Westinghouse Government Services Group Welfare Benefits Plan 4350 Northern Pike, Room 217C Monroeville, PA 15146-2886
Dental Coverage • Which dental services are covered or not covered, • Find a network provider, • MetLife's Allowance for a specific service, or • Any other detailed dental coverage questions	**Network Administrator:** MetLife Group Number: 300316 **Phone Number:** 1-800-890-3600 Dental Claims (Direct Number: 1-800-942-0854) **Address:** Metropolitan Life Insurance Company One Madison Avenue New York, NY 10010 Claims may be filed at: MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282 **To obtain provider information:** 1-800-474-7371 **Web site:** www.mybenefitsdirectory.com/westinghouse (Direct Web site: www.metlife.com/mybenefits)	**Appeals Authority for Initial Appeal:** MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282 Appeals Authority for Final Appeal: The Administrative Committee of Westinghouse Government Services Group Welfare Benefits Plan 4350 Northern Pike, Room 217C Monroeville, PA 15146-2886

COBRA	**Administrator:** HM Benefits Administrators, Inc. **Phone Number:** 1-800-890-3600 (Direct Number: 1-800-457-3397) **Address:** HM Benefits Administrators, Inc. COBRA Administration P.O. Box 535054 Pittsburgh, PA 15253-0054 **Web site:** www.mybenefitsdirectory.com/westinghouse (Direct Web site: www.highmarklife.com)	Eligibility for COBRA coverage: **Appeals Authority:** The Administrative Committee of Westinghouse Government Services Group Welfare Benefits Plan 4350 Northern Pike, Room 217C Monroeville, PA 15146-2886
Direct Billing	**Administrator:** HM Benefits Administrators, Inc. **Phone Number:** 1-800-890-3600 (Direct Number: 1-888-421-3273) **Address:** HM Benefits Administrators, Inc. Billing Department P.O. Box 382004 Pittsburgh, PA 15251	NA
Employee Assistance Program • Obtain employee assistance program help, or • Find a network provider	**Network Administrator:** ValueOptions **Phone Number:** 1-800-890-3600 (Direct Number: 877-866-4911) **Address:** ValueOptions P.O. Box 1347 Latham, NY 12110-8847 **Web site for on-line library:** www.mybenefitsdirectory.com/westinghouse (Direct Web site: www.achievesolutions.net/westinghouse)	**Appeals Authority for Initial Appeal:** ValueOptions P.O. Box 1347 Latham, NY 12110-8847 **Appeals Authority for Final Appeal:** The Administrative Committee of Westinghouse Government Services Group Welfare Benefits Plan 4350 Northern Pike, Room 217C Monroeville, PA 15146-2886

Total Disability Management • To report your disability	**Administrator:** Hartford Life and Accident Company **Phone Number:** 1-800-890-3600 (Direct Number: 1-800-303-9744) **Address:** Hartford Life and Accident Company National Accounts Service Center Disability Claims PO Box 946710 Maitland, FL 32794-6710	Not Applicable
Accident & Sickness Benefit Coverage	**Insurance Carrier:** Hartford Life and Accident Company Contract Number: SR-83115809 **Phone Number:** 1-800-890-3600 (Direct Number: 1-800-303-9744) **Address:** Hartford Life and Accident Company National Accounts Service Center Disability Claims PO Box 946710 Maitland, FL 32794-6710	**Appeals Authority:** Hartford Life and Accident Company National Accounts Service Center Disability Claims PO Box 946710 Maitland, FL 32794-6710
Long-Term Disability Benefit Coverage	**Insurance Carrier:** Hartford Life and Accident Company Contract Number: SR-83115808 **Phone Number:** 1-800-890-3600 (Direct Number: 1-800-303-9744) **Address:** Hartford Life and Accident Company National Accounts Service Center Disability Claims PO Box 946710 Maitland, FL 32794-6710	**Appeals Authority:** Hartford Life and Accident Company National Accounts Service Center Disability Claims PO Box 946710 Maitland, FL 32794-6710

Basic Life Insurance Coverage and Basic AD&D Insurance Coverage	**Insurance Carrier:** MetLife Contract Number: 96934-G **Phone Number:** 1-800-890-3600 (Direct Number: 1-800-638-6420) **Address:** Metropolitan Life Insurance Company One Madison Avenue New York, NY 10010	**Appeals Authority:** Metropolitan Life Insurance Company One Madison Avenue New York, NY 10010
Business Travel Accident Insurance Coverage	**Insurance Carrier:** Life Insurance Company of North America (administered by CIGNA) Contract Number: ABL-668161 **Phone Number:** 1-800-890-3600 **Address:** Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192	**Appeals Authority:** Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192
Group Universal Life (GUL)	**Insurance Carrier:** MetLife Contract Number: 96532 **Phone Number:** 1-800-890-3600 (Direct Number: 1-800-GET-MET8 or 1-800-438-6388) **Address:** Metropolitan Life Insurance Company One Madison Avenue New York, NY 10010 **Web site:** www.mybenefitsdirectory.com/westinghouse (Direct Web site: www.metlife.com/mybenefits)	**Appeals Authority:** Metropolitan Life Insurance Company One Madison Avenue New York, NY 10010

Additional/Supplemental Life Insurance Coverage	**Insurance Carrier:** MetLife Contract Number: 96934-G **Phone Number:** 1-800-890-3600 (Direct Number: 1-800-638-6420) **Address:** Metropolitan Life Insurance Company One Madison Avenue New York, NY 10010	**Appeals Authority:** Metropolitan Life Insurance Company One Madison Avenue New York, NY 10010
Dependent Life Insurance Coverage	**Insurance Carrier:** MetLife Contract Number: 96934-G **Phone Number:** 1-800-890-3600 (Direct Number: 1-800-638-6420) **Address:** Metropolitan Life Insurance Company One Madison Avenue New York, NY 10010	**Appeals Authority:** Metropolitan Life Insurance Company One Madison Avenue New York, NY 10010
Personal Accident Insurance Coverage	**Insurance Carrier:** MetLife Contract Number: 96934-G **Phone Number:** 1-800-890-3600 (Direct Number: 1-800-638-6420) **Address:** Metropolitan Life Insurance Company One Madison Avenue New York, NY 10010	**Appeals Authority:** Metropolitan Life Insurance Company One Madison Avenue New York, NY 10010

Health and Day Care Spending Accounts • Which health care services are reimbursable under the Health Care Spending Account • Which day care services are reimbursable under the Day Care Spending Account	**Administrator:** FlexBen Corporation **Phone Number:** 1-800-890-3600 (Direct Number: 1-800-577-3322) **Address:** FlexBen Corporation PO Box 14053 Lexington, KY 40511 Faxed claims: 1-877-FLEXBEN (1-877-353-9236) **Web site:** www.mybenefitsdirectory.com/westinghouse (Direct Web site: www.ee-commerce.com)	**Appeals Authority for Initial Appeal:** FlexBen Corporation 2250 Butterfield Drive Troy, MI 48084 **Appeals Authority for Final Appeal:** The Administrative Committee of Westinghouse Government Services Group Welfare Benefits Plan 4350 Northern Pike, Room 217C Monroeville, PA 15146-2886
Long-Term Care Insurance Coverage	**Insurance Carrier:** CNA Group Benefits Contract Number: 9970TQ-WGSG **Phone Number:** 1-800-890-3600 (Direct Number: 1-877-777-9072) **Address:** CNA Group Benefits CNA Plaza Chicago, IL 60685-0001	**Appeals Authority:** CNA Group Benefits CNA Plaza Chicago, IL 60685-0001

Appendix L – How to File a Claim

For Claims Regarding:	Follow this procedure:
Eligibility under the Plan	To file an eligibility claim for yourself or your dependents, contact the Westinghouse Benefits Center. The representative will give you instructions and a form for filing your eligibility claim.
Medical Coverage	If you go to a network provider, generally no claim forms are required. If you go to an out-of-network provider, you may need to pay for the service up front and file a claim form for reimbursement. If you need a medical claim form, you can obtain one through the *Your Benefits Resources*™ Web site, Highmark Blue Cross Blue Shield's Web site, or by calling Highmark Blue Cross Blue Shield. You can reach the *Your Benefits Resources*™ and Highmark Blue Cross Blue Shield's Web sites through *ConnectBenefits On-Line* at www.mybenefitsdirectory.com/westinghouse; you can reach Highmark Blue Cross Blue Shield through Benefits Connection at 1-800-890-3600. Please follow the instructions on the claim form and send the claim to the address noted on the form.
Mental Health and Substance Abuse Treatment Coverage	If you pre-certify your visits through ValueOptions and receive care from a network provider, generally no claim forms are required. If you go to an out-of-network provider or you do not pre-certify your care, you may need to pay for the service up front and file a claim form. When you make the appointment, it may be a good idea to ask your provider if he/she can file the claim for you. If you need a ValueOptions claim form, you can obtain one through the *Your Benefits Resources*™ Web site, or by calling ValueOptions. You can reach the *Your Benefits Resources*™ Web site through *ConnectBenefits On-Line* at www.mybenefitsdirectory.com/westinghouse; you can reach ValueOptions through Benefits Connection at 1-800-890-3600. Please follow the instructions on the claim form and send the claim to the address noted on the form.

For Claims Regarding:	Follow this procedure:
Prescription Drug Coverage	Prescriptions can be filled at network retail pharmacies by presenting your identification card at the time of service. Before any prescriptions can be filled using the mail service pharmacy, the Mail Service Prescription Enrollment Order Form needs to be completed in full for each covered person and mailed to EHS's mail service pharmacy, which is Express Pharmacy Services (EPS); PO Box 270; Pittsburgh, PA 15230-9949. If prescriptions are mailed along with this form, and any other time a prescription is mailed to the mail service pharmacy, the Member Number needs to be written on the back of the prescription. When an out-of-network pharmacy is used, claims are submitted by completing the Prescription Drug Claim Form, attaching necessary documentation and mailing to Eckerd Health Services (EHS); PO Box 2860; Pittsburgh, PA 15230-2860. If you need the Mail Service Prescription Enrollment Order Form or the Prescription Drug Claim Form, you can obtain it through the *Your Benefits Resources*™ Web site, EHS' Web site, or by calling EHS. You can reach the *Your Benefits Resources*™ and EHS's Web sites through *ConnectBenefits On-Line* at www.mybenefitsdirectory.com/westinghouse; you can also reach EHS through Benefits Connection at 1-800-890-3600. Please follow the instructions on the claim form and send the claim to the address noted on the form.
Vision Coverage	If you go to a VSP provider, no claim forms are required. You pay the Co-payment for the examination and the cost of frames, lenses, etc., minus the Westinghouse-appropriate benefit amount, to the VSP provider at the time the service is rendered. If you choose to visit an out-of-network provider, no claim forms are required. You pay for the services and materials, then submit an itemized bill (which must include the Westinghouse employee's Social Security Number) to VSP. Please see Appendix K for the claims mailing address.

For Claims Regarding:	Follow this procedure:
Special Programs with Medicare Hospital Program	To file a claim under SPM's Hospital Program, you need to first file the claim under Medicare. Once you get the Medicare Summary Notices, you can then file a claim form for reimbursement. If you need a Special Programs with Medicare Hospital Program's claim form, you can obtain one through the *Your Benefits Resources*™ Web site or by calling HM Benefits Administrators, Inc., the administrator for Special Programs with Medicare Hospital Program claims. You can reach the *Your Benefits Resources*™ Web site through *ConnectBenefits On-Line* at www.mybenefitsdirectory.com/westinghouse; you can reach HM Benefits Administrators, Inc. for Special Programs with Medicare Hospital Program claims through Benefits Connection at 1-800-890-3600. Please follow the instructions on the claim form and send the claim to the address noted on the form.
Dental Coverage	The use of a MetLife dental claim form is really up to each dentist – network or out-of-network. Many dentists are filing electronically or are using their own claim form, which is fine. When you make an appointment, it may be a good idea to ask the dentist if you need to bring a MetLife dental claim form with you. If you need a dental claim form, you can obtain one through the *Your Benefits Resources*™ Web site, MetLife's Web site, or by calling MetLife. You can reach the *Your Benefits Resources*™ and MetLife's Web sites through *ConnectBenefits On-Line* at www.mybenefitsdirectory.com/westinghouse; you can also reach MetLife through Benefits Connection at 1-800-890-3600. The MetLife Dental Claim Form may also be used for predetermination of dental benefits. Please follow the instructions on the claim form and send the claim to the address noted on the form.
Salary Continuance **Accident & Sickness Benefit Coverage** **Long-Term Disability Benefit Coverage**	To report a disability claim: • First call your manager to report your first day of absence from work. • See your medical provider, bring the "Authorization to Release Information" card, have the provider make a copy of the release on the other side of this card, and sign and date the copy for the provider's files. • Call Hartford Life and Accident Company through Benefits Connection at 1-800-890-3600 (direct dial 1-800-303-9744), Monday – Friday, 8 AM – 8 PM Eastern Time, as soon as possible, but within 7 days after your first absence from work to begin the claim process.

For Claims Regarding:	Follow this procedure:
Life and Accident Insurance Coverage (excluding Group Universal Life)	To file a claim, call the Westinghouse Benefits Center. A Benefits Center representative will send you a claim form. Please follow the instructions on the claim form and send the form back to the Westinghouse Benefits Center.
Group Universal Life	To file a claim, call MetLife by calling Benefits Connection and selecting Group Universal Life at the appropriate prompt. MetLife will send you a claim form. Please follow the instructions on the claim form and send the form back to MetLife.
Health Care Spending Account	You will need to submit a Request for Reimbursement Form for each Health Care Spending Account reimbursement that you are requesting. If you need a copy of the claim form, you can obtain one through the *Your Benefits Resources*™ Web site, FlexBen Corporation's Web site, or by calling FlexBen Corporation. You can reach the *Your Benefits Resources*™ and Flex Ben's Web sites through *ConnectBenefits On-Line* at www.mybenefitsdirectory.com/westinghouse; you can also reach FlexBen through Benefits Connection at 1-800-890-3600. Please follow the instructions on the Request for Reimbursement Form and send the form to FlexBen at the address noted on the form.
Day Care Spending Account	You will need to submit a Request for Reimbursement Form for each Day Care Spending Account reimbursement that you are requesting. If you need a copy of the claim form, you can obtain one through the *Your Benefits Resources*™ Web site, FlexBen Corporation's Web site, or by calling FlexBen Corporation. You can reach the *Your Benefits Resources*™ and Flex Ben's Web sites through *ConnectBenefits On-Line* at www.mybenefitsdirectory.com/westinghouse; you can also reach FlexBen through Benefits Connection at 1-800-890-3600. Please follow the instructions on the Request for Reimbursement Form and send the form to FlexBen at the address noted on the form.
Long-Term Care Insurance Coverage	To file a claim, call CNA by calling Benefits Connection at 1-800-890-3600 and selecting Long-Term Care Insurance Coverage at the appropriate prompt. CNA will send you a claim form. Please follow the instructions on the claim form and send the form back to CNA.

Appendix M – Business Travel Accident Insurance Coverage

GROUP BUSINESS TRAVEL ACCIDENT INSURANCE CERTIFICATE

Westinghouse Government Service

LIFE INSURANCE COMPANY OF NORTH AMERICA
1601 Chestnut Street, Philadelphia, PA 19192
A Stock Insurance Company

ACCIDENT ONLY
CERTIFICATE OF INSURANCE

Covered Person:
Effective Date:
Beneficiary:

We, the Life Insurance Company of North America, have issued Blanket Accident Policy No. **ABL-668161** to the Policyholder:

WESTINGHOUSE GOVERNMENT SERVICE

We certify that you are covered by the Blanket Policy while you are a member of the classes of the Policyholder, as described:

I All full-time Employees of Westinghouse Government Service.

II All part-time Employees of Westinghouse Government Service.

III Employees over age 70 of Westinghouse Government Service.

Your coverage will begin on the later of: (1) the effective date shown above; and (2) the date you entered the class described above. Your coverage will end on the date that: (1) you are no longer in the class described above; or (2) the Blanket Policy is terminated. Termination will not affect a claim for a loss which occurs while you are covered by the Blanket Policy.

Your coverage is described in this Certificate. You should read it with care so you will understand your coverage. This is not the insurance contract. The Blanket Policy is the only contract under which benefits are paid. You may examine it at the office of the Policyholder.

John K. Leonard, President

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

Plan Effective Date: January 1, 2000

Your benefit amounts are shown below. If no benefit amount is shown, then you are not covered for that benefit.

Class I:	Coverage A:	**Accidental Death And Dismemberment Benefit** Principal Sum: Two (2) times Basic Annual Earnings to a maximum of $750,000.
	Applicable Hazards:	Schedule IV-A (2229), Schedule IV-H (Hijacking & Air Piracy), Schedule IV-Terrorism, Schedule IV-W War Risk (2239)
Class II:	Coverage A:	**Accidental Death And Dismemberment Benefit** Principal Sum: One (1) times Basic Annual Earnings to a maximum of $100,000 with a minimum benefit of $25,000.
	Applicable Hazards:	Schedule IV-A (2229), Schedule IV-H (Hijacking & Air Piracy), Schedule IV-Terrorism, Schedule IV-W War Risk (2239)
Class III:	Coverage A:	**Accidental Death And Dismemberment Benefit** Principal Sum: Two (2) times Basic Annual Earnings to a maximum of $750,000.
	Applicable Hazards:	Schedule IV-A (2229), Schedule IV-H (Hijacking & Air Piracy), Schedule IV-Terrorism, Schedule IV-W War Risk (2239)

Classes I, II, and II are not covered for Coverages B, C and D.

"Basic Annual Earnings" , as used above, means: The Covered Person's base earnings, as set by the Employer for the Employee's job classification. This does not include overtime, bonuses or commissions.

Total Limit of Liability - We will not pay more than $7,500,000 per accident.

If, but for this provision, we would pay more than this amount, then the benefits we will pay to each covered person will be reduced in the same proportion, so that the total amount we will pay is the maximum amount shown above.

SCOPE OF COVERAGE

We will pay the benefits described in this Certificate only for the types of accidents described in Schedule IV of the policy. A copy of this schedule is attached. **The policy covers accidents only. It does not pay benefits for loss caused by sickness. Please read your Certificate with care.**

DESCRIPTION OF COVERAGE

BENEFITS FOR ACCIDENTAL LOSS OF LIFE, LIMB, SIGHT, SPEECH, HEARING AND PARALYSIS:

If bodily injuries result in: (1) the death of the Insured; or (2) dismemberment or loss of sight, within one year from the date of accident covered by the policy, we will pay the benefits provided for such loss; provided, however, that if the Insured sustains more than one such loss as the result of any one accident, we will pay only the one largest amount to which the Insured is entitled. This amount will not exceed the Principal Sum.

Loss of Life	The Principal Sum
Loss of two or More Members	The Principal Sum
Loss of Speech and Hearing (both Ears)	The Principal Sum
Quadriplegia (total paralysis of both upper and lower limbs)	The Principal Sum
Loss of One Member	One-Half the Principal Sum
Paraplegia (total paralysis of both lower limbs)	One-Half the Principal Sum
Loss of Speech	One-Half the Principal Sum
Loss of Hearing (both ears)	One-Half the Principal Sum
Hemiplegia (total paralysis of upper and lower limbs on one side of body)	One-Half the Principal Sum
Loss of Thumb and Index Finger of the same hand	One-Quarter the Principal Sum

"Principal Sum" is stated elsewhere in the Policy.

"Member" means hand, foot, and eye.

"Loss" means with regard to hand or foot, complete severance through or above the wrist or ankle joint; loss of an eye means total and irrecoverable loss of sight; loss of speech means complete inability to communicate audibly in any degree; loss of hearing means irrecoverable loss of hearing, which cannot be corrected by any hearing aid or device; loss of thumb and index finger means severance of each through or above the joint closest to the wrist. (In California, loss of a thumb or index finger means loss by complete severance of at least one whole phalanx of each.) (In South Carolina, the loss of four whole fingers from one hand equals the loss of one hand.)

"Paralysis" means loss of use, without severance, of a limb. This loss must be determined by a physician to be complete and not reversible.

"Severance" means complete separation and dismemberment of the limb from the body.

Coverage B: Permanent Total Disability--We will pay this benefit if:

a) you are injured by one of the types of accidents described in Schedule IV, which happens while you are covered for this benefit, and
b) you become totally disabled as a direct result, and from no other cause, within 30 days after the accident; and
c) you remain totally disabled for 12 straight months; and
d) you are then permanently and totally disabled.

The amount of this benefit is the amount shown on the Schedule of Benefits page, minus any amounts we have paid under Coverage A for the accident. If the amount shown on the Schedule of Benefits is a periodic amount, then we will pay this amount until:

a) you die, or are no longer permanently and totally disabled; or
b) the total we have paid for the accident under Coverages A and B is the Principal Sum shown on the Schedule of Benefits page.

You will be deemed "totally disabled" if you can not do at all the substantial and material duties of your type of work. You will be deemed "permanently and totally disabled" if you are not able to do any work for which you are or may become qualified by reason of your education, experience or training; and if you are not expected to be able to do any such work for the rest of your life.

DESCRIPTION OF COVERAGE (Continued)

Coverage C: Total Disability Weekly Benefit--We will pay this benefit if:

a) you are injured by one of the types of accidents described in Schedule IV, which happens while you are covered for this benefit, and

b) you become totally disabled as a direct result, and from no other cause, within 30 days after the accident.

The amount of this benefit is shown on the Schedule of Benefits page. This benefit will begin on the first day after the end of the Waiting Period (shown on the Schedule of Benefits page). We will pay this benefit until:

a) you die or are no longer totally disabled; or

b) we have paid this benefit for the Maximum Period shown on the Schedule of Benefits page; or

c) you qualify for benefits under Coverage A or B.

You will be deemed "totally disabled" if:

a) During the Waiting Period, and for the next 12 months after that, if you can not do all the substantial and material duties of your type of work.

b) After that, if you can not do at all any work for which you are or may become qualified by reason of your education, experience, or training.

Coverage D: Medical Expense Benefit--If you are injured by one of the types of accidents described in Schedule IV, which happens while you are covered for this benefit, then we will pay this benefit for the services listed below, which you need as a direct result of the injury, and from no other cause, within a year of the accident:

a) Stays in a hospital.

b) Medical or surgical treatment by a doctor.

c) The services of licensed or graduate nurses.

d) X-ray examinations.

e) Professional ambulance service from the scene of the accident to the nearest hospital.

The treatment must begin not more than 60 days after the accident.

The amount of this benefit will be the actual cost of these services, minus the deductible amount (if any) shown on the Schedule of Benefits page. The deductible must be satisfied once for each accident.

This benefit will be reduced to the extent that benefits are payable for the medical services under: (i) any employer sponsored health care plan; or (ii) any government program or any law, including any Worker's Compensation law.

We will not pay more than the maximum amount shown on the Schedule of Benefits page, for all medical treatment needed as a result of any one accident.

EXCLUSIONS

We will not pay benefits for loss caused by or resulting from:

a) Suicide, attempted suicide, or whenever you injure yourself on purpose, while sane or insane. (In Missouri only, this does not apply if he was insane.)

b) War or acts of war, whether or not declared; except to the extent that it is provided for in Schedule IV-W or IV-H.

c) Injury while you are on full time active duty in any armed forces. We will return the pro rata portion of premiums paid to cover you during a period of such service.

d) Taking part in a felony.

e) Travel or flight in any spacecraft; or flight in any aircraft, except to the extent that this hazard is provided for by name in Schedule IV.

f) Any bacterial infection that was not caused by an accidental cut, wound or food poisoning.

This is an accident only policy. We will not pay benefits for loss caused by or resulting from illness, disease, or bodily infirmity.

SCHEDULE IV- A
HAZARDS INSURED AGAINST

Unless otherwise provided, we will pay benefits only once for any one covered loss, even if it was caused by more than one covered hazard.

24 HOUR COVERAGE WHILE TRAVELING ON BUSINESS
AWAY FROM THE PREMISES OF THE POLICYHOLDER (Owned Aircraft Not Covered)

Applies to Classes I, II, and III

We will pay the benefits described in the policy for any accident which occurs anywhere in the world while you, on a business trip, are traveling or making a short stay:

a) away from the Policyholder's premises in the city of permanent assignment; and
b) on business for the Policyholder, and in the course of the Policyholder's business.

All such trips must be authorized by the Policyholder.

This coverage does not apply:

a) while you are commuting between your home and place of work; or
b) during personal deviations made by you.

"Personal deviation," as used here, means an activity that is not reasonably related to the Policyholder's business, and not incidental to the business trip.

This coverage will start at the actual start of a trip. It does not matter whether the trip starts at your home, place of work, or other place. This coverage will end when you:

a) arrive at your home or place of work, whichever happens first; or
b) make a personal deviation.

If you travel to another city, and are expected to remain there for more than 60 days, this shall be deemed a change in your city of permanent assignment.

Exposure And Disappearance--This coverage includes exposure to the elements, after the forced landing, stranding, sinking, or wrecking of a vehicle in which you were traveling on business for the Policyholder.

You will be presumed to have died, for purposes of this coverage, if:

a) you are in a vehicle which disappears, sinks, or is stranded or wrecked, in the course of a trip which would be covered by the policy; and
b) your body is not found within a year of the accident.

Aircraft Restrictions--If the accident happens while you are riding in, or getting on or off of, an aircraft, we will pay benefits, but only if:

a) you are riding as a passenger only, and not as a pilot or member of the crew; and
b) the aircraft has a valid certificate of airworthiness; and
c) the aircraft is flown by a pilot with a valid license; and
d) the aircraft is not being used for: (i) crop dusting, spraying, or seeding; fire fighting; sky writing; sky diving or hang gliding; pipeline or power line inspection; aerial photography or exploration; racing, endurance tests, stunt or acrobatic flying; or (ii) any operation which requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on).

Owned Aircraft Not Covered--We will not pay benefits if the aircraft is owned, leased or controlled by the Policyholder, or any of its subsidiaries or affiliates. An aircraft will be deemed to be "controlled" by the Policyholder if the Policyholder may use it as it wishes for more than 10 straight days, or more than 15 days in any year.

SCHEDULE IV-H -- HIJACKING AND AIR PIRACY

We agree to pay the benefits described in the policy for accidents described in Schedule IV, which are caused by hijacking, air piracy, or any unlawful seizure or attempted seizure of an aircraft, to the extent that this hazard is not covered by the policy.

Premiums And Coverage Subject To Change--The premiums and benefits may be changed at any time by agreement between the Policyholder and the Insurance Company. This may be done as needed to reflect conditions which, in the opinion of the Policyholder or the Insurance Company, change the hijacking and air piracy risk.

Termination--The Policyholder may cancel this hijacking and air piracy coverage at any time by sending written notice to us at our home office, at the address shown on page 1. This coverage will be canceled when we receive the Policyholder's notice, or later if so specified.

We may cancel this coverage at any time by sending the Policyholder at least 10 days' written notice to their most recent address in our records.

We will promptly return any unearned premium that the Policyholder has paid. However, this is not a condition of termination.

Change or termination of this coverage will not affect a claim which begins while this coverage is in force.

Except for the above, this rider does not change the policy in any way.

LIFE INSURANCE COMPANY OF NORTH AMERICA

John K. Leonard, President

LM-2016 8

SCHEDULE IV-TERRORISM

We agree to pay the benefits described in this policy for accidents described in Schedule IV which are caused by an act or acts of terrorism, to the extent that this hazard is not covered by the policy. This coverage is subject to the terms set forth below.

> "**ACTS OF TERRORISM**" means premeditated, politically motivated violence perpetrated against a non-combatant by: a) persons not acting on behalf of a sovereign state; or b) clandestine state agents.

Premiums And Coverage Subject To Change--The premiums and benefits for this rider may be changed at any time by agreement between the Policyholder and us. This may be done as needed to reflect conditions which, in the opinion of the Policyholder or us, change the terrorism risk.

Termination--The Policyholder may cancel this terrorism coverage at any time by sending written notice to us at our home office, at the address shown on page 1. This coverage will be canceled when we receive their notice, or later if so specified.

Exclusions--The following exclusion applies only to the Coverage under this rider: Loss caused by or resulting from nuclear radiation or the release of nuclear energy.

We may cancel this coverage at any time by sending the Policyholder at least 10 days' written notice to their most recent address in our records.

We will promptly return any unearned premium that the Policyholder has paid. However, this is not a condition of termination.

Change or termination of this coverage will not affect a claim which begins while this coverage is in force.

Unless otherwise provided, we will pay benefits only once for any one covered loss, even if it was caused by more than one covered hazard.

LIFE INSURANCE COMPANY OF NORTH AMERICA

John K. Leonard, President

LM-9B75 9

SCHEDULE IV-W -- WAR RISK INSURANCE

We agree to pay the benefits described in this policy for accidents described in Schedule IV which are caused by war or acts of war. Exclusion (b) is hereby deleted. This coverage is subject to the terms set forth below.

Area Covered--This coverage includes loss caused by or resulting from war or acts of war only in the area described below:

Anywhere in the world except: Iraq, Libya, Yugoslavia (Serbia and Montenegro) and Kosovo

This coverage does not include: (i) the United States; and (ii) any nation of which the covered person is a citizen.

Total Limit of Liability--We will not pay more than $7,500,00 per accident occurrence for the war risk benefits provided by this amendment. This limit shall apply to injuries sustained from all acts of war in any consecutive 72 hour period. If, but for this provision, we would pay more than the above stated amount, then the benefits we will pay to each covered person will be reduced in the same proportion, so that the total amount we will pay for war risk coverage is the maximum shown above.

Premiums and Coverage Subject to Change--The premiums, benefits, and area covered may be changed at any time by agreement between the Policyholder and us. This may be done as needed to reflect conditions which, in the opinion of the Policyholder or us, change the war risk exposure.

Termination--The Policyholder may cancel this war risk coverage at any time by sending written notice to us at our home office, at the address shown on page 1 of the policy. This coverage will be canceled when we receive the Policyholder's notice, or later if so specified.

We may cancel this coverage at any time by sending the Policyholder at least 10 days' written notice to their most recent address in our records.

We will promptly return any unearned premium that the Policyholder has paid. However, this is not a condition of termination.

Change or termination of this coverage will not affect a claim which begins while this coverage is in force.

Except for the above, this rider does not change the policy or certificate in any way.

LIFE INSURANCE COMPANY OF NORTH AMERICA

John K. Leonard, President

LM-1E46 10 (2239)

PAYMENT OF CLAIMS

Claim Procedures: Notice of Claim--If any covered loss occurs or begins, you must send us written notice within 30 days, or as soon after that as is reasonably possible. This notice should state your name and the policy number. This notice should be sent to us at our home office, at the address shown on page 1, or to an agent authorized by us. We will then send you claim forms.

Claim Procedures: Proof Of Loss--The claim forms must be sent back to us no more than 90 days after a covered loss occurs or ends, or as soon after that as is reasonably possible. If we have not provided claim forms within 15 days after the notice of claim, you should send us other proof of loss by the date claim forms would be due. This proof of loss should include written proof of the occurrence, type and amount of loss.

Payment Of Claims: When Paid--Claims will be paid as soon as we receive due proof of loss. If a claim covers benefits for more than 4 weeks, we will pay all amounts due at the end of each 4 weeks. If there are any benefits due at the end of the period claimed, we will pay them as soon as we receive due proof of loss.

Payment Of Claims: Accidental Death Benefits--Benefits paid on account of your death will be paid to the beneficiary you have chosen. This choice must be in writing and filed with us; or filed with the Policyholder, if we have agreed in advance.

If you have not chosen a beneficiary, or if there is no beneficiary alive when you die, we will pay this benefit:

1) to your spouse, if living.
2) If not, in equal shares to your living children.
3) If there are none, in equal shares to your living parents.
4) If there are none, in equal shares to your living brothers and sisters.
5) If there are none, to your estate.

Instead of a lump sum payment, you (while you are living) or your beneficiary (after your death) may choose installment payments from one of the settlement options we are then offering.

Payment Of Claims: Other Benefits--All other benefits will be paid to you, if you are living. If not, we will pay your beneficiary or your estate.

Selection Or Change Of Beneficiary; Assignment--You have the right to select or change the beneficiary. You do not need the consent of the beneficiary to make such a change, to assign your rights or benefits, or to change your coverage. We will not be bound by an assignment, or by a selection or change of beneficiary, until we receive a signed copy of it. We are not responsible for its validity or sufficiency.

Physical Examinations And Autopsy--At our expense, we may have a person claiming benefits examined as often as reasonably necessary while a claim is pending. We may also make an autopsy in case of death where it is not forbidden by law.

Legal Actions--No one may sue for benefits less than 60 days after due proof of loss is submitted, nor more than 3 years (Kansas: 5 years; South Carolina: 6 years) after the date claim forms are due.

UNDERWRITTEN BY:
LIFE INSURANCE COMPANY OF NORTH AMERICA
a CIGNA company

CLASSES 1, 2 and 3

01-01

CIGNA Group Insurance
Life ● Accident ● Disability

Appendix N – Health & Welfare Benefits in Retirement

Eligibility

If you are a Full-Time Employee and Retire directly from active service with the Employer:

- **With at least 10 years of Eligibility Service:** You are eligible for Pre-Medicare medical coverage, dental coverage, basic life insurance, and additional/supplemental life insurance, according to the following provisions.
- **With at least 5 but less than 10 years of Eligibility Service:** You are only eligible for Special Programs with Medicare (SPM) when you are eligible for Medicare, according to the following provisions. You are NOT eligibile for for Pre-Medicare medical coverage, dental coverage, basic life insurance, and additional/supplemental life insurance.

If you Retire directly from active service with the Employer with at least 10 years of Eligibility Service	
Medical Coverage	**Pre-Medicare Medical Coverage** • If you are not Medicare-eligible, pre-Medicare coverage under the Premium PPO with retiree contributions begins on the first day a retiree is eligible for retiree coverage. You may also enroll your Eligible Dependents in the Premium PPO if you choose it for yourself. • **A retiree who does not continue coverage upon retirement will never thereafter be eligible for coverage under the Westinghouse Government Services Group Welfare Benefits Plan for Retirees.** • If you die, your spouse may continue Pre-Medicare coverage until your spouse becomes Medicare-eligible (at which time your spouse is eligible for the coverage described below) or remarries; your eligible dependent children may continue Pre- Medicare coverage until they are no longer Eligible Dependents. • **If a retiree or a survivor of a retiree stops pre-Medicare medical coverage for any reason, he/she will never be able to re-enroll in that coverage for any reason at any time in the future.**

If you Retire directly from active service with the Employer with at least 10 years of Eligibility Service	
	When you become Medicare-eligible • <u>If you are enrolled in Pre-Medicare medical coverage</u>, you and your spouse will automatically be enrolled in Special Programs with Medicare (SPM) when each of you become eligible for Medicare and you will be billed at the rate in effect at that time. Your eligible dependent children will continue to be covered under the Premium PPO. You must be enrolled in SPM in order for your spouse to be enrolled in SPM and for your eligible dependent children to be enrolled in the Premium PPO. If you die, your spouse may continue SPM coverage until your spouse remarries and your eligible dependent children may continue pre-Medicare coverage until they are no longer Eligible Dependents. • SPM coverage is NOT a Medicare supplement. • **If a retiree or a survivor of a retiree stops SPM coverage for any reason, he/she will never be able to re-enroll in SPM for any reason at any time in the future.**
Dental Coverage	• If you are not Medicare-eligible, dental coverage under the Premium PPO with retiree contributions begins on the first day a retiree is eligible for retiree coverage. You may also enroll your Eligible Dependents in the Premium PPO if you choose it for yourself. • **A retiree who does not continue coverage upon retirement will never thereafter be eligible for coverage under the Westinghouse Government Services Group Welfare Benefits Plan for Retirees.** • If you die, your spouse may continue dental coverage until your spouse becomes Medicare-eligible or remarries; your eligible dependent children may continue dental coverage until they are no longer Eligible Dependents. • **If a retiree or a survivor of a retiree stops dental coverage for any reason, he/she will never be able to re-enroll in that coverage for any reason at any time in the future.**
Employee Assistance Program	Coverage ends at midnight on your last day worked. You may continue coverage for yourself and your Eligible Dependents through COBRA paying full COBRA rates until the COBRA continuation period expires.
Accident & Sickness Benefit Coverage	Coverage ends at midnight on your last day worked. If you are receiving Accident & Sickness Benefit Coverage when you Retire, your benefit continues to the earlier of 26 weeks or the date that you are no longer Totally Disabled.
Long-Term Disability Benefit Coverage	Coverage ends at midnight on your last day worked. If you are receiving long-term disability income benefits when you Retire, your long-term disability income benefit continues according to the provisions of that coverage.
Basic Life Insurance Coverage	Your coverage amount in retirement is $5,000.
Basis AD&D Insurance Coverage, Business Travel Accident Insurance Coverage, and Personal Accident Insurance Coverage for Yourself and Your Dependents	Coverage ends at midnight on your last day worked.

If you Retire directly from active service with the Employer with at least 10 years of Eligibility Service	
Additional/Supplemental Life Insurance Coverage	If you were enrolled for this coverage on December 31, 1991 and have been continuously covered since then, you may continue this coverage when you Retire with certain provisions. If you Retire before age 62, you must pay to continue your coverage to age 62. The full coverage amount remains in effect until the 1st of the month after your 62nd birthday. Coverage starts to reduce on the 1st of the month following your 62nd birthday or the date of retirement, whichever occurs later, by 5% of the insurance amount that you had immediately prior to retirement. This same dollar reduction repeats on the 1st of each following month until your coverage amount is 1/3 of the amount in effect on December 31, 1991. The Employer pays for this coverage for retirees after the 1st of the month after you reach age 62.
Group Universal Life	You may continue GUL directly through the GUL insurance carrier according to the provisions of that coverage. The GUL insurance carrier will bill you for the cost of your coverage.
Dependent Life Insurance Coverage	Coverage ends at midnight on your last day worked. You may apply for an individual converted life insurance policy if you apply to the insurance carrier and pay for the coverage within 31 days after coverage stops.
Long-Term Care Insurance Coverage	You may continue LTC directly through the LTC insurance carrier according to the provisions of that coverage. The LTC insurance carrier will bill you for the cost of your coverage.
Health Care Spending Account	If you participated in the Health Care Spending Account immediately prior to your retirement, you may continue to contribute to your Account for the balance of the calendar year through COBRA. You may also choose to not make Health Care Spending Account contributions after your retirement. If you choose not to make further contributions through COBRA, you will only be able to submit claims for reimbursement of expenses that were incurred before your retirement date, and in the same calendar year as your retirement date.
Day Care Spending Account	No additional contributions to the Day Care Spending Account are permitted after you Retire. You may continue to have access to your Account for eligible expenses (i.e., expenses that you incurred to enable you and your spouse (if married) to work) incurred during the calendar year in which you retired, up to the balance remaining in your Account.

If you are Laid-Off or Permanently Separated, and are eligible to Retire directly from active service with the Employer with at least 10 years of Eligibility Service as of the date of your Layoff or Permanent Separation:

- Benefits are described in the chart above effective on your date of Layoff or Permanent Separation.

For Part-Time Employees, benefits if you Retire directly from active service are described in the chart above except that:

- **Medical and dental coverage:** Coverage ends at midnight on your last day worked. You may continue coverage for yourself and your Eligible Dependents through COBRA paying full COBRA rates until the COBRA continuation period expires.
- **Basic Life Insurance Coverage**: Coverage ends at midnight on your last day worked. You may apply for an individual converted life insurance policy if you apply to the insurance carrier and pay for the coverage within 31 days after coverage stops.

If you Retire directly from active service with the Employer with at least 5 but less than 10 years of Eligibility Service	
Medical Coverage	Coverage ends at midnight on your last day worked. You may continue coverage for yourself and your Eligible Dependents through COBRA paying full COBRA rates until the COBRA continuation period expires. **When you become Medicare-eligible** • You and your spouse will automatically be enrolled in Special Programs with Medicare (SPM) when each of you become eligible for Medicare and you will be billed at the rate in effect at that time. You must be enrolled in SPM in order for your spouse to be enrolled in SPM. If you die, your spouse may continue SPM coverage until your spouse remarries. • SPM coverage is NOT a Medicare supplement. • **If a retiree or a surviving spouse of a retiree stops SPM coverage for any reason, he/she will never be able to re-enroll in SPM for any reason at any time in the future.**
Dental Coverage and the Employee Assistance Program	Coverage ends at midnight on your last day worked. You may continue coverage for yourself and your Eligible Dependents through COBRA paying full COBRA rates until the COBRA continuation period expires.
Accident & Sickness Benefit Coverage	Coverage ends at midnight on your last day worked. If you are receiving Accident & Sickness Benefit Coverage when you Retire, your benefit continues to the earlier of 26 weeks or the date that you are no longer Totally Disabled.
Long-Term Disability Benefit Coverage	Coverage ends at midnight on your last day worked. If you are receiving long-term disability income benefits when you Retire, your long-term disability income benefit continues according to the provisions of that coverage.
Basic Life Insurance Coverage, Dependent Life Insurance Coverage and Additional/Supplemental Life Insurance Coverage	Coverage ends at midnight on your last day worked. You may apply for an individual converted life insurance policy if you apply to the insurance carrier and pay for the coverage within 31 days after coverage stops.
Basis AD&D Insurance Coverage and Business Travel Accident Insurance Coverage, and Personal Accident Insurance Coverage for Yourself and Your Dependents	Coverage ends at midnight on your last day worked.
Group Universal Life	You may continue GUL directly through the GUL insurance carrier according to the provisions of that coverage. The GUL insurance carrier will bill you for the cost of your coverage.
Long-Term Care Insurance Coverage	You may continue LTC directly through the LTC insurance carrier according to the provisions of that coverage. The LTC insurance carrier will bill you for the cost of your coverage.
Health Care Spending Account	If you participated in the Health Care Spending Account immediately prior to your retirement, you may continue to contribute to your Account for the balance of the calendar year through COBRA. You may also choose to not make Health Care Spending Account contributions after your retirement. If you choose not to make further contributions through COBRA, you will only be able to submit claims for reimbursement of expenses that were incurred before your retirement date, and in the same calendar year as your retirement date.

If you Retire directly from active service with the Employer with at least 5 but less than 10 years of Eligibility Service	
Day Care Spending Account	No additional contributions to the Day Care Spending Account are permitted after you Retire. You may continue to have access to your Account for eligible expenses (i.e., expenses that you incurred to enable you and your spouse (if married) to work) incurred during the calendar year in which you retired, up to the balance remaining in your Account.

If you are Laid-Off or Permanently Separated, and are eligible to Retire directly from active service with the Employer with at least 5 years but less than 10 years of Eligibility Service as of the date of your Layoff or Permanent Separation:

- Benefits are described in the chart above effective on your date of Layoff or Permanent Separation, except that you will pay the active rates for medical and dental coverage for the first (12) months, then full COBRA rates until COBRA period expires.

Appendix O – Long-Term Care Insurance Coverage

Policy Number: **9970TQ-WGS**

MASTER APPLICATION
FOR
LONG TERM CARE INSURANCE

The Applicant applies to the Continental Casualty Company ("CCC", "We", "Our" or "Us") for a Group Long Term Care Insurance Policy ("Master Policy") based on the statements and representations below.

1. NAME AND ADDRESS OF APPLICANT

Westinghouse – WGS
Westinghouse Government Services Group ("Westinghouse")
P.O. Box 355
Pittsburgh, Pennsylvania 15230-0355

1A. Situs State: Idaho

2. INITIAL ENROLLMENT PERIOD

Begins: October 30, 2000
Ends: November 30, 2000

3. MASTER POLICY EFFECTIVE DATE

January 1, 2001

4. ELIGIBILITY CLASSES

No person may be an Insured under more than one Eligibility Class.

A. Class A – Employees

An **Eligible** employee of Westinghouse, or Westinghouse Government Environmental Services Company, LLC who is **Actively at Work**.

Eligible means an employee who works more than 32 hours per week. An individual hired as a temporary or seasonal employee, through a contract or any other arrangement who is not listed as an employee on the employer's payroll records is not an Eligible employee. This rule applies even if a court or administrative agency determines that the individual is a leased employee under the Internal Revenue Code, or is an employee under common law or other legal standards.

Actively at Work means the Employee is physically at his or her usual place of business performing the regular duties of his or her work.

B. Class B – Spouses of Employees

The Spouse of a member of Class A.

The Spouse must be the current, lawful spouse of the **Eligible** Employee.

C. Class C – Parents and Grandparents

The Parent, Parent-in-law, Grandparent, or Grandparent-in-law of a member of Class A.

Parent means a natural parent; an adoptive parent; or any other person who is legally married to a natural parent or adoptive parent. The spouse of the Parent or Parent-in-law must be the current, lawful spouse of the Parent or Parent-in law.

Grandparent means a natural grandparent; an adoptive grandparent; or any person who is legally married to a natural or adoptive grandparent. The spouse of the Grandparent or Grandparent-in-law must be the current, lawful spouse of the Grandparent or Grandparent-in-law.

D. Class D – Retirees

A Retiree of Westinghouse.

Retiree means a former **Eligible** Employee of Westinghouse who has retired from active service with Westinghouse and has met the qualifications to receive a retirement benefit.

E. Class E – Spouses of Retirees

The Spouse of a member of Class D.

The Spouse of the Retiree must be the current, lawful spouse of the Retiree.

F. Class F – Individuals Insured under John Hancock Policy Number 27278-LTC

Individuals who as of January 1, 2001 are in an active, premium paying status Policy Number 27278-LTC issued to Westinghouse by John Hancock who elect to transfer their coverage to this CCC policy. This election will be made by the method indicated in the offer to **transition** to this CCC policy. The offer to **transition** may be made by Us prior to the effective date of this policy and may be made also subsequent to the effective date of the Policy.

Transition means the individual elects to cancel their coverage under John Hancock Policy Number 27278-LTC and begin coverage under this CCC policy.

5. ENROLLMENT, UNDERWRITING CRITERIA & COVERAGE EFFECTIVE DATE

A. Class A – Employees

(1) An **Eligible** Employee may enroll/apply for coverage anytime during the year.

(2) The following underwriting criteria shall apply:

a. Coverage shall be granted without demonstrating evidence of insurability if the **Eligible** Employee enrolls:
   i. During the Initial Enrollment Period, if he or she is **Actively at Work**;
   ii. Within 31 days of his or her return to work, if he or she was not **Actively at Work** during the Initial Enrollment Period; or
   iii. Within 31 days following his or her date of hire.

b. Coverage shall be granted subject to Our approval of evidence of insurability, if the **Eligible** Employee applies for coverage at any other time.

(3) The **Eligible** Employee must be **Actively at Work** on the Coverage Effective Date for coverage to take effect. If the **Eligible** Employee is on a scheduled vacation, he or she will

be deemed to be **Actively at Work** on the Coverage Effective Date. If the **Eligible** Employee is on sabbatical, disability, medical leave, or other leave of absence on the Coverage Effective Date, coverage will take effect on the first regular scheduled day he or she returns to work.

Coverage shall take effect as follows:

a. If the **Eligible** Employee enrolls during the Initial Enrollment Period, coverage will be effective on the Master Policy Effective Date.

b. If the **Eligible** Employee is not **Actively at Work** during the Initial Enrollment Period and enrolls within 31 days of returning to work, or if the **Eligible** Employee enrolls within 31 days following his or her date of hire, coverage will be effective as follows:

   i. If We receive and process the enrollment form on or before the 12th of the month, the insurance will take effect on the first day of the month immediately following receipt.

   ii. If We receive and process the enrollment form after the 12th of the month, the insurance will take effect on the first day of the second month following receipt.

c. If the **Eligible** Employee applies for coverage at any other time, coverage shall be effective as follows:

   i. If We approve and process the evidence of insurability on or before the 12th of the month, the insurance will take effect on the first day of the month immediately following approval.

   ii. If We approve and process the evidence of insurability after the 12th of the month, the insurance will take effect on the first day of the second month following approval.

NOTE: In the event that a court or administrative agency determines that an individual hired as a temporary or seasonal employee is a leased employee under the Internal Revenue Code, or is an employee under common law or other legal standards and notwithstanding the provisions of Section 4.A. above, determines that such an individual shall be permitted to obtain coverage under this policy, coverage to such individuals shall be granted subject to Our approval of evidence of insurability.

B. Class B – Spouses of **Eligible** Employees

(1) The Spouse of an **Eligible** Employee may apply for coverage at anytime during the year.
(2) Coverage shall be granted subject to Our approval of evidence of insurability.
(3) Coverage shall take effect as follows:

   a. If We approve and process the evidence of insurability on or before the 12th of the month, the insurance will take effect on the first day of the month immediately following approval.

   b. If We approve and process the evidence of insurability after the 12th of the month, the insurance will take effect on the first day of the second month following approval.

C. Class C – Parents and Grandparents

(1) Parents, Parents-in-law, Grandparents, and Grandparents-in-law, may apply for coverage at anytime the **Eligible** Employee is **Actively at Work**.
(2) Coverage shall be granted subject to Our approval of evidence of insurability.

(3) Coverage shall take effect on the first of the month that falls on or next following the date We approve and process the evidence of insurability.

D. Class D & Class E – Retirees and Spouses of Retirees

(1) Retirees and their Spouses may apply for coverage at anytime.

(2) Coverage shall be granted subject to Our approval of evidence of insurability.

(3) Coverage shall take effect on the first of the month that falls on or next following the date We approve and process the evidence of insurability.

E. Class F – Individuals Insured under John Hancock Policy Number 27278-LTC

(1) Insureds in this Class must elect to enroll pursuant to the terms of the **transition** offer.
(2) Coverage shall be granted without demonstrating evidence of insurability.
(3) Coverage under this Master Policy shall take effect on the Master Policy Effective Date; however, Insureds in this Class shall be deemed to have coverage from the Insured's individual original effective date under the prior policy for purposes of calculating time and age.

6. SCHEDULE OF BENEFITS

A. Long Term Care Benefit

(1) Long Term Care Benefit for Nursing Home Care

100% of the Eligible Expense per day of Nursing Home Care or Alternate Care Facility, not to exceed the Daily Benefit, as determined by the option elected by the eligible person.

(2) Long Term Care Benefit for Community Based Care

100% of the Eligible Expense per day of Community Based Care, not to exceed 50% of the Daily Benefit for Nursing Home Care, as elected by the eligible person.

(3) Long Term Care Benefit for Hospice Care Facility

100% of the Eligible Expense per day, not to exceed the Daily Benefit for Nursing Home Care, as elected by the eligible person.

Option	Daily Benefit for Nursing Home Care	Corresponding Daily Benefit for Community Based Care	Corresponding Daily Benefit for Hospice Care Facility
1	$ 70.00	$35.00	$ 70.00
2	$130.00	$65.00	$130.00
3	$190.00	$95.00	$190.00

B. Lifetime Maximum Benefit

1825 times (5 Years) the Daily Benefit for Nursing Home Care, as elected by the eligible person.

Option	Daily Benefit for Nursing Home Care	Corresponding Lifetime Maximum Benefit
1	$ 70.00	$127,750.00
2	$130.00	$237,250.00
3	$190.00	$346,750.00

C. Waiting Period

90 Calendar Days from certification as Chronically Ill.

D. Waiver of Premium

After completion of the Waiting Period.

E. Caregiver Benefit

100% of the Eligible Expense per day, not to exceed 25% of the Daily Benefit for Nursing Home Care, as elected by the eligible person, with a maximum Annual Benefit of 30 times the Daily Caregiver Benefit.

Option	Daily Benefit for Nursing Home Care	Corresponding Daily Caregiver Benefit	Corresponding Annual Caregiver Benefit
1	$ 70.00	$18.00 *	$ 540.00
2	$130.00	$33.00 **	$ 990.00
3	$190.00	$48.00***	$1,440.00

* $17.50 rounded to $18.00
** $32.50 rounded to $33.00
*** $47.50 rounded to $48.00

F. Caregiver Training Benefit

100% of the Eligible Expense per training, not to exceed three (3) times the Daily Benefit for Community Based Care, as elected by the eligible person.

Option	Daily Benefit for Nursing Home Care	Corresponding Daily Benefit for Community Based Care	Corresponding Benefit for Caregiver Training
1	$ 70.00	$35.00	$105.00
2	$130.00	$65.00	$195.00
3	$190.00	$95.00	$285.00

G. Temporary Bed Holding Benefit

100% of the Eligible Expense per day, not to exceed the Daily Benefit for Nursing Home Care, as elected by the eligible person, with a maximum Annual Benefit of 21 calendar days.

Option	Daily Benefit for Nursing Home Care	Corresponding Daily Benefit for Temporary Bed Holding	Corresponding Annual Temporary Bed Holding Benefit
1	$ 70.00	$ 70.00	$1,470.00
2	$130.00	$130.00	$2,730.00
3	$190.00	$190.00	$3,990.00

H. Emergency Alert Benefit

100% of the Eligible Expense per month for rental or lease of Emergency Alert equipment, not to exceed the Daily Benefit for Community Based Care, as elected by the eligible person.

Option	Daily Benefit for Nursing Home Care	Corresponding Daily Benefit for Community Based Care	Corresponding Monthly Emergency Alert Benefit
1	$ 70.00	$35.00	$35.00
2	$130.00	$65.00	$65.00
3	$190.00	$95.00	$95.00

I. Benefit Account

If the Insured stops paying premiums after three (3) years of continuous coverage, Long Term Care coverage will be continued. Daily Benefit levels remain the same; however, the Lifetime Maximum Benefit will be reduced to the greater of the total premiums paid or 30 times the Daily Benefit for Nursing Home Care.

J. Inflation Protection - Guaranteed Benefit Increase Option

Insureds will be offered opportunities to increase the Maximum Daily Benefit Levels and Lifetime Maximum on the third anniversary of the Effective Date of the Master Policy, and each third anniversary thereafter. The offered increase will be not less than a compounded annual five percent (5%) rate. Insureds are not obligated to purchase additional coverage in order for their policies to remain in effect.

7. PREMIUM PAYMENT MODES

A. For **Actively at Work** Employees and their Spouses, Premiums are payable by deductions from a payroll account.

B. For all other Insureds, including former **Actively at Work** Employees and Spouses on continuation policies, Premiums are payable on a quarterly, semi-annual, or annual direct-billed basis, or via monthly Electronic Funds Transfer, unless We agree to another mode of payment.

8. PREMIUM DUE DATES

A. Initial Premium Due Date:

(1) For **Actively at Work** Employees and their Spouses under payroll deduction, the initial Premium Due Date is 50 days after the Master Policy Effective Date.

(2) For all other Insureds, the initial Premium Due Date is the Insured's Certificate Effective Date.

B. Subsequent Premium Due Dates:

(1) For **Actively at Work** Employees and their Spouses under payroll deduction, subsequent Premium Due Dates will be monthly, as billed.

(2) For all other Insureds, including former **Actively at Work** Employees and Spouses on continuation policies, subsequent Premium Dues Dates will be monthly, quarterly, semi-annually, or annual, as billed, depending upon the Premium Payment Mode selected Insured.

9. RENEWAL UNDERWRITING STANDARDS

After the Master Policy has been in effect for five (5) years, We require at least 20 Insureds be covered under it to maintain the Master Policy.

10. CHANGES AND CANCELLATIONS BY THE INSURED

A. Requests to increase the Benefits Level may be made at any time in writing to Us. Increases to the Benefits Level shall be granted subject to Our approval of evidence of insurability.
B. Requests to reduce the Benefits Level may be made at any time in writing to Us.
C. Requests to cancel coverage may be made at any time in writing to Us.

11. PREMIUM RATES

See Addendum 1 attached to this Master Application.

12. CONTRACT TYPE

This contract is intended to be a Qualified Long Term Care contract as defined under section 7702B(b) of the Internal Revenue Code of 1986.

13. MISCELLANEOUS

A. Initial Renewal Period:	36 months (3 Years)
B. Subsequent Renewal Periods:	12 months
C. Period of Notice for Non-Renewal:	60 days
D. Initial Premium Rate Guarantee Period:	36 months (3 Years)
E. Period of Notice of Premium Rate Changes:	60 days

14. EFFECTIVE DATE

This Master Application is attached to and made a part of Group Long Term Care Policy Number **9970TQ-WGS**. The Master Policy is Effective **January 1, 2001**, if We accept the Master Application. This Master Application cancels and replaces any prior Master Applications attached to the Master Policy. The Effective Date of the Master Application is **January 1, 2001**.

Applicant: **Westinghouse Government Services Group**

ADDENDUM 1

TABLE OF PREMIUM RATES

POLICYHOLDER: Westinghouse Government Services Group

POLICY NUMBER: 9970TQ-WGS **1825x LIFETIME MAXIMUM**

AGE ON EFFECTIVE DATE OF COVERAGE	MONTHLY PREMIUM FOR DAILY BENEFIT SELECTED		
	$70	$130	$190
<25	4.20	7.80	11.40
25	4.78	8.88	12.98
26	4.85	9.01	13.17
27	4.97	9.23	13.49
28	5.13	9.53	13.93
29	5.28	9.80	14.33
30	5.49	10.20	14.90
31	5.68	10.55	15.42
32	5.93	11.02	16.11
33	6.26	11.63	16.99
34	6.64	12.33	18.03
35	7.07	13.13	19.20
36	7.55	14.03	20.50
37	8.06	14.97	21.88
38	8.57	15.92	23.26
39	9.12	16.94	24.76
40	9.79	18.18	26.56
41	10.41	19.33	28.25
42	11.05	20.52	29.99
43	11.70	21.72	31.75
44	12.36	22.95	33.55
45	13.18	24.48	35.78
46	13.98	25.96	37.94
47	14.89	27.65	40.40
48	15.85	29.43	43.02
49	16.86	31.32	45.77
50	18.16	33.72	49.28
51	19.49	36.20	52.91
52	21.11	39.20	57.30
53	23.00	42.71	62.42
54	25.11	46.64	68.17
55	27.70	51.45	75.20
56	30.32	56.30	82.29
57	33.21	61.68	90.15
58	36.47	67.73	98.99
59	40.06	74.39	108.72
60	44.25	82.19	120.12
61	48.21	89.53	130.85
62	52.18	96.91	141.63
63	55.84	103.70	151.57
64	59.27	110.08	160.88

ADDENDUM 1
TABLE OF PREMIUM RATES
POLICYHOLDER: Westinghouse Government Services Group
POLICY NUMBER: 9970TQ-WGS **1825x LIFETIME MAXIMUM**

AGE ON EFFECTIVE DATE OF COVERAGE	MONTHLY PREMIUM FOR DAILY BENEFIT SELECTED		
	$70	$130	$190
65	63.49	117.92	172.34
66	67.89	126.07	184.26
67	73.47	136.44	199.41
68	79.91	148.40	216.89
69	86.92	161.42	235.92
70	94.94	176.31	257.68
71	104.42	193.92	283.42
72	115.82	215.10	314.37
73	129.29	240.11	350.92
74	144.51	268.38	392.24
75	161.29	299.53	437.78
76	179.41	333.19	486.98
77	198.67	368.96	539.24
78	218.93	406.58	594.24
79	238.30	442.56	646.82
80	260.86	484.46	708.06
81	282.50	524.65	766.80
82	308.07	572.13	836.19
83	336.06	624.11	912.16
84	366.36	680.38	994.41
85	394.44	732.53	1070.62
86	425.76	790.70	1155.65
87	456.08	847.01	1237.93
88	481.07	893.42	1305.77
89	505.17	938.18	1371.19
90	533.28	990.38	1447.47

Continental Casualty Company

CNA
For All the Commitments You Make®

CNA Plaza *A Stock Company*
Chicago, Illinois 60685

"We," "Our," and "Us" are Used to refer to the Continental Casualty Company.

Holder: Westinghouse Government Services Group
Policy Number: 9970TQ-WGS (the "Policy")
Policy Effective Date: January 1, 2001

THIS POLICY IS A QUALIFIED LONG TERM CARE INSURANCE CONTRACT UNDER THE FEDERAL TAX CODE.

The Policy is issued in consideration of the statements made in the Master Application, any other required evidence of insurability for participants and the payment of premium. We agree with the Holder to insure eligible persons based on the statements made in the Master Application. We promise to pay benefits for loss covered by the Policy.
The Policy is not a Medicare Supplement policy. If the Insured is eligible for Medicare, the Medicare Supplement Buyer's Guide is available from Us for review.
SPS1AA-TQ

EFFECTIVE DATE AND TERM

The Policy starts on the Policy Effective Date. The Insured's coverage starts on the Coverage Effective Date stated in the Master Application and stays in force for the period for which premium has been paid.

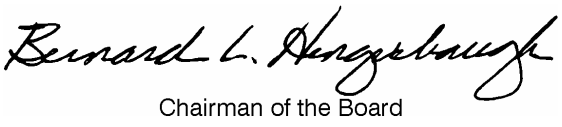
The Holder may elect not to renew the Policy at any time by written notice to us. Termination of the Policy will be the later of: (a) The effective date of non-renewal stated in the written notice; or (b) The end of the Period for Notice of Non-Renewal stated in the Schedule. This period starts on the date we receive the written notice from the Holder.

We guarantee to renew the Policy at the end of each renewal period, unless: (a) the Holder fails without good and sufficient cause to duly perform in good faith any obligation pertaining to the Policy; or (b) the number of eligible persons insured is less than required by our Renewal Underwriting Standards stated in the Schedule. The Initial Renewal Period starts on the Policy Effective Date. Each Subsequent Renewal Period starts on the day after the preceding period ends. The length of these periods is stated in the Schedule. If we elect not to renew the Policy, it terminates on the later of: (a) The effective date of non-renewal stated in our written notice; or (b) The end of the Period for Notice of Non-Renewal stated in the Schedule. This period starts on the date the Holder receives the written notice from us.

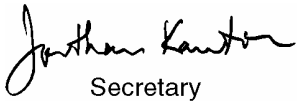
If the Insured is paying premiums directly to us, we will notify him or her of any non-renewal by written notice at least 31 days before the Policy terminates.

All insurance periods start and end at 12:01 a.m., Standard Time, at the Holder's address stated in the Master Application.
SPS2BA

Signed for the Continental Casualty Company at its Home Office, CNA Plaza, Chicago, Illinois 60685.



Chairman of the Board



Secretary

GROUP LONG TERM CARE

INSURANCE POLICY

SR-LTCP-11-TQ

DEFINITIONS

The terms defined here are capitalized whenever they are used.
SGD1AA

Alternate Care Facility means a facility or other supportive residence which is engaged primarily in providing ongoing care and related services to residents in one location and meets all of the following criteria:

1. Provides 24 hour care and/or supervision and is able to provide Qualified Long Term Care Services sufficient to support needs resulting from the Insured being Chronically Ill;
2. The facility has at least one supervised, trained and ready to respond employee on duty at all times to provide care;
3. Offers 3 meals a day and accommodates special dietary needs;
4. Is licensed or accredited by the appropriate agency to provide such care, if such licensing or accreditation is required by the state in which care is received, or, if licensing is not required, has a quality of care program;
5. Maintains specific policies and procedures, consistent with state requirements, for handling medical emergencies and trains staff to follow those procedures;
6. Maintains accessible files or records for each resident which includes up to date information listing that resident's physician, dentist and other community based health care providers;
7. Has appropriate methods and procedures for recording, handling and administering drugs and biologicals, as needed; and
8. If the facility provides dementia care, has a secured physical plant and specialized dementia programs.

Alternate Care Facility does not mean a Long Term Care facility, hospital or clinic, assisted living facility not meeting the above criteria or a place which operates primarily for the treatment of alcoholics or drug addicts. However, care or services for assisted living facilities not meeting the Alternate Care Facility definition may be covered subject to the conditions of the Alternate Plan of Care provision.
SGDAC1AA

Community Based Care consists of the categories of care listed and defined below.

(a) Home Health Care means the following types of care when received from a Home Health Care Provider at the Insured's Residence:

(1) Occupational, physical, respiratory or speech therapy, or nutritional services;

(2) Nursing care performed by a registered nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN);

(3) Personal Care Services provided by a home health care aide or by a medical social worker;

(4) Maintenance Services provided by a home health care aide or homemaker; or

(5) Hospice care.

A **Home Health Care Provider** is an entity which:
(1) Has an agreement as a provider of Home Health Care under Medicare; or
(2) Is certified or licensed by the state in which it is located as a provider of such care; or

(3) Is accredited as a provider of such care by the National League of Nursing, American Public Health Association or Joint Commission on Accreditation of Healthcare Organizations.

A **Home Health Care Provider** may also be an RN, LPN or LVN working within the scope of his or her license.
SGDH1CB-TQ

(b) Adult Day Care means a community based group program of health, social and related support services for Insureds living at home whose condition is such that they cannot be left alone. It does not include 24-hour care. The facility providing this type of care must meet the certification or licensing requirements of the state in which it is located. If the state does not certify or license adult day care centers, the facility must be certified by a recognized accrediting agency.
SGDH2AA

(c) Adult Foster Care means a residential alternative to Nursing Home Care for Insureds whose condition is such that they cannot live alone, but whose needs can be met in a private home. The provider of this type of care must be certified or licensed by the state in which it is located.
SGDH4AA

(d) Assisted Living Care means Qualified Long Term Care Services provided by a living arrangement in a facility other than an Alternate Care facility for Insureds whose condition is such that it precludes total independent living, but which does not require the level of care available in a Nursing Home. The facility must charge separately for room charges and board/rent charges.
SGDH3CA

Disability means any disorder resulting in the Insured being Chronically Ill.
SGD28AA-TQ

Eligible Expense means the actual expense incurred by the Insured for Long Term Care and other services covered by the Policy. For Community Based Care, it does not include the cost of transportation (except for Adult Day Care), supplies and rent or those costs which the Insured would incur regardless of whether the Insured is Chronically Ill.
SGD2AA-TQ

Hospice Care means care designed to alleviate the physical, emotional, social and spiritual discomforts resulting from the last stages of a terminal disease and to provide emotional support to the primary caregiver and family.
SGD20AB

Informal Care means care or services provided by an Informal Caregiver in the Insured's Residence. It includes care and services as defined in the Home Health Care provision but must be greater than care or services the Informal Caregiver provides for other members residing in the Insured's Residence. Informal Care must be monitored on a periodic basis by a registered nurse or a care manager approved by Us.
SGD12BA

Informal Caregiver means the primary caregiver of the Insured who:

(1) is approved by Us as being experienced in or trained to provide Informal Care;

(2) is physically capable of providing Informal Care to the Insured; and

(3) is not paid as a Home Health Care Provider under the Policy.
SGD13BA

Insured means the eligible person whose coverage is in force under the Policy.
SGD3AA

Insured's Residence means wherever the Insured lives, except a hospital or Nursing Home.
SGD4AA

Licensed Health Care Practitioner means any physician, registered professional nurse (RN) or licensed social worker, acting within the scope of his or her license.
SGD24AA-TQ

Lifetime Maximum Benefit means the most We will pay in benefits due to the Insured who has been certified to be Chronically Ill. This maximum is stated in the Schedule. All amounts paid to the

Chronically Ill Insured, under any benefit provision in or attached to the Policy, including the Alternate Plan of Care Benefit, count towards the maximum.
SGD5AA-TQ

Long Term Care means Qualified Long Term Care Services providing Nursing Home Care, Hospice Care, Alternate Care Facility, and/or Community Based Care.
SGD6IA-TQ

Maintenance Services means any care which is received due to the Insured having a Disability. This may include homemaker services such as cooking, cleaning, laundering, organizing bills for payment and running errands.
SGD29AA-TQ

Master Application means the Holder's application attached to the Policy when issued.
SGD7AA

Nursing Home means a place which:

(a) Is licensed by the state in which it is located;
(b) Provides Nursing Home Care on an inpatient basis under the supervision of a physician;
(c) Has nursing services provided by or under the supervision of a registered nurse (RN), licensed vocational nurse (LVN), or licensed practical nurse (LPN);
(d) Keeps a daily medical record of each patient; and
(e) Is either a freestanding facility or a ward, wing, unit or swing bed of a hospital or other institution.

SGDN1AA

Nursing Home Care consists of the categories of care listed and defined below when received in a Nursing Home.

(a) **Nursing Care.** Nursing services which require the training and skills of an RN, LVN or LPN.
(b) **Custodial Care.** Services which are above the level of room and board but do not require the continuous attention of trained medical or paramedical personnel. They may be provided by persons without professional skills or training.

SGDN2AA

Personal Care Services means assistance with Activities of Daily Living or similar personal assistance such as walking, using a wheelchair, walking with braces or walker, a cane or other walking aid device.
SGD25AA-TQ

Plan of Care means a program of care and treatment initiated by and approved in writing by a Licensed Health Care Practitioner.
SGD26AA-TQ

Qualified Long Term Care Services means preventive, therapeutic, mitigating and rehabilitative services and Maintenance or Personal Care Services, which:

1. are required due to a Disability, and
2. are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

SGD27AA-TQ

Schedule means the schedule of benefits.
SGD8AA

Waiting Period means the number of consecutive calendar days, stated in the Schedule, which must pass before the Long Term Care Benefit becomes payable and before We start to waive premiums.
SGD9BA

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

SGDE1AA

Chronically Ill means an Insured who has been certified by a Licensed Health Care Practitioner as being unable to perform (without substantial assistance from another individual) at least 2 Activities of Daily Living for a period of 90 days, due to an Activities of Daily Living Impairment or requiring Substantial Supervision to protect the Insured from threats to health and safety due to a Severe Cognitive Impairment.

The Insured will not be considered Chronically Ill unless within the preceding 12 months a Licensed Health Care Practitioner has certified that the Insured meets the above requirements.
SGD23BA-TQ

Activities of Daily Living Impairment means the Insured's inability to perform without human assistance or substantial supervision from another person at least two of the Activities of Daily Living listed and defined below**.**
SGD22AA-TQ

Bathing. Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
SGDQ2CA-9

Continence. The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for a catheter or colostomy bag.
SGDQ2BA-6

Dressing. Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
SGDQ2BA-2

Eating. Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
SGDQ2BA-1

Toileting. Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
SGDQ2BA-3

Transferring. Moving into or out of a bed, chair or wheelchair.
SGDQ2BA-8

Severe Cognitive Impairment means a loss or deterioration in the Insured's intellectual capacity that is measured by clinical evidence and standardized tests that reliably measures impairment in the following areas:

1. Short term or long term memory,
2. Orientation as to people, places or time, and
3. Deductive or abstract reasoning.

SGDQ3EA

Substantial Supervision means continual supervision, which may include cueing by verbal prompting, gestures, or other demonstrations, by another person that is necessary to protect the severely cognitively impaired Insured from threats to his or her safety.
SGD32AA

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

Exclusions - We will not pay benefits for the following:
SGL2AA

1 Loss due to or resulting from war or an act of war whether declared or undeclared.
SGL2AA-1

2 Long Term Care which would be provided without charge in the absence of insurance.
SGL2AA-3

3 Treatment for neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder which is not of organic origin. Alzheimer's Disease and similar dementias are covered, subject to the provisions of the Policy.
SGL2AA-4

4 Nursing Home Care received in a hospital or clinic or a rehabilitation hospital, except as provided in the definition of Nursing Home; or in a facility or section of a facility which operates primarily for the treatment of alcoholics or drug addicts or the mentally ill.
SGL2DB-5

5 Long Term Care received outside the United States and its possessions.
SGL2AA-6

6 Long Term Care to the extent that benefits are payable under Medicare or would be so reimbursable but for the application of a deductible or coinsurance amount.
SGL2AA-7-TQ

Waiting Period - The Insured must complete the Waiting Period before the Long Term Care Benefit becomes payable. The Waiting Period starts on the date We receive written notice of claim at Our Home Office. For benefits to become payable after the Waiting Period, the Insured must have been certified as Chronically Ill during the entire Waiting Period. If We receive proof that the Insured was Chronically Ill prior to the date We receive the written notice of claim, We will begin the Waiting Period starting on the date the Disability began.
SGL3EB-TQ

Coordination of Benefits - Benefits under the Policy shall be reduced by any amounts payable in Long Term Care benefits under Workers' Compensation, the Occupational Disease Act or Law or Medicare. The days on which Long Term Care is received will count towards satisfying the Waiting Period and, if applicable, the Waiver of Premium Qualification Period, subject to the provisions of the Policy.

Benefits under the Policy will coordinate with benefits payable under another group long term care plan in the following manner.

1. When the Policy is a primary plan, its benefits are determined before those of the other group long term care plan and without considering the other plan's benefits. When the Policy is a secondary plan, its benefits are determined after those of the other group long term care plan and may be reduced because of the other plan's benefits. Where there are more than two plans covering the Insured, the Policy may be a primary plan as to one or more other plans, and may be a secondary plan as to a different plan or plans.
2. Where there is a basis for a claim under the Policy and another group long term care plan, the Policy is the secondary plan which has its benefits determined after those of the other plan. The Policy is primary when the other plan has rules coordinating its benefits with those of the Policy and both the Policy's rules and the other plan's rules require the Policy's benefits be determined first.
3. Coverage under the Policy will be considered primary for active employees as described in the Master Application.

Benefits under the Policy will coordinate with benefits payable under another group health plan in the following manner.

1. Where there is a basis for a claim under the Policy and a group health plan or Medicare, the Policy is the secondary plan which has its benefits determined after those of the other plan. The Policy is primary when the other plan has rules coordinating its benefits with those of the Policy and both the Policy's rules and the other plan's rules require the Policy's benefits be determined first.

When the benefits of the Policy are reduced as described above, each benefit is reduced in proportion. The amount paid is then charged against any applicable benefit limit of the Policy.

Certain information is needed to apply the above Coordination of Benefits rules. We have the right to decide which information We need and to collect that information from or give that information to any other organization or person. We need not notify the Insured of the receipt or disbursement of information. Each person claiming benefits under the Policy must provide us with any facts We need to pay the claim.

A payment made under another plan may include an amount which should have been paid under the Policy. If it does, We may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under the Policy. We will not have to pay that amount again.

If We pay more than We should have paid under this provision, We may recover the excess from one or more of the following:

1. The persons We have paid or the person for whom We have paid;
2. Insurance companies; or
3. Other organizations.

SGL4AB

LONG TERM CARE BENEFIT

We will pay the Long Term Care Benefit stated in the Schedule, subject to the conditions below.

(a) The Insured must be certified as Chronically Ill by a Licensed Healthcare Practitioner.

(b) The Long Term Care Benefit will be paid pursuant to a Plan of Care provided by a Licensed Healthcare Practitioner.

(c) The Long Term Care must start while the Insured's coverage is in force.

(d) The Lifetime Maximum Benefit must not yet have been reached.

(e) The terms of the Limitations or Conditions on Eligibility for Benefits provision must be met.

SGNH1AB-TQ

INTERRUPTION IN CARE

If the Insured has completed the Waiting Period, We will consider the Long Term Care for the same or for a related condition to be continuing without interruption until 6 months pass during which the Insured receives no Long Term Care due to such condition. When Long Term Care due to the same or a related condition recurs, the Insured must complete the full Waiting Period before benefits again become payable and premiums are again waived for Long Term Care due to such condition.

SGNH2BA

WAIVER OF PREMIUM

We will waive premiums starting with the first premium due after the Insured completes the Waiting Period. If the Insured is confined in a Nursing Home or Alternate Care Facility during the Waiting Period and remains confined continuously until the Waiting Period has been completed, We will waive the premium retroactively from the date the Insured entered the Nursing Home or Alternate Care Facility but no earlier than the date the Waiting Period began. We will continue to waive premiums until no benefits have been paid for 6 months.

If premiums are being paid other than monthly, the Insured will be placed on the monthly premium payment mode when we start to waive premiums. We will then refund any unearned monthly premiums, starting with the premium of the first full month for which premiums are waived.

When waiver of premium stops, the Insured's coverage may be continued in force by payment of the first modal premium due after the date it stops. The modal premium will be the same as in effect prior to the date waiver of premium started, subject to any change in the premium rates which may have occurred as provided in the Payment of Premium provision.

SGS3BA(wes)

ALTERNATE PLAN OF CARE BENEFIT

If the Insured requires Long Term Care, We may pay for alternate services, devices or types of care, pursuant to a written Alternate Plan of Care, developed by or with a Licensed Healthcare Practitioner.

Any alternate care, including the benefits to be paid, may be adopted, as long as it is mutually agreeable to the Insured, the Insured's physician and Us. No benefits will be payable under this provision until an agreement is reached. Agreement to participate in an alternate Plan of Care will waive neither the Insured's nor Our rights.

The Alternate Plan of Care may specify special treatments or different sites or levels of care. Some of the care the Insured may receive may be different from that otherwise covered by the Policy. In this case, benefits will be paid at the levels specified and agreed to in the alternate Plan of Care.

SGA1AB-TQ

INDIVIDUAL TERMINATIONS

The Insured's coverage under the Policy terminates on the earliest of the dates below. Unless termination occurs under Paragraphs (c) or (d) of this provision, the Insured's coverage may be continued in force as provided in the Continuation of Coverage Due to Termination provision.

(a) Except as stated in the Continuation of Coverage Due to Death or Divorce of Spouse provision, the date the Insured is no longer eligible for coverage, as provided in the Master Application.

(b) On the date the Policy terminates.

(c) The end of the grace period of an unpaid premium, unless non-payment is due to a clerical error made by Us or the Holder.

(d) The date the Lifetime Maximum Benefit is reached.

SGS4AA

CONTINUATION OF COVERAGE DUE TO TERMINATION

The Insured becomes eligible for continuation of coverage on the date his or her coverage under the Policy terminates as provided in Paragraphs (a) and (b) of the Individual Terminations provision. Coverage will be continued under a new group policy (the "continuation policy") subject to the conditions below:

(a) The Insured must remit the first quarterly premium to Us for the continued coverage and We must receive it within 60 days from the date coverage terminates under the Policy or, if a claim started before termination, when waiver of premium stops. The Insured must remit the first quarterly premium to Us regardless of whether a bill has been sent by Us or received by the Insured. The Insured not receiving a bill for continuation of coverage is not to be considered a clerical error made by Us or the Holder.

The first quarterly premium for the continued coverage is three times the Insured’s monthly premium and is due on the date coverage terminates under the Policy. The first quarterly premium should be paid by check, made out to ‘Continental Casualty Company’ and identify the Insured’s Certificate Number and Social Security Number. The remittance should be sent to CNA-GLTC, P.O. Box 946760, Maitland, FL 32794-6760.

(b) Upon receipt of the Insured’s remittance of the first quarterly premium for continuation coverage, We will verify that the Insured is eligible for continuation and provide ongoing billings. All future premiums under the continuation policy are due quarterly. The Insured must remit them directly to Us. We will consider requests for payment modes other than quarterly.

(c) Coverage will be continued under the continuation policy with the same benefits and provisions as the Policy, such that the Insured is left in the same position as if coverage had not terminated.

(d) The Insured's coverage under the continuation policy is effective as of the date coverage terminates under the Policy. The Insured will not be covered or receive benefits simultaneously under the Policy and the continuation policy.

(e) There is no continuation of coverage if Extension of Benefits stops due to the Lifetime Maximum Benefit having been reached.

SGS5DA

CONTINUATION OF COVERAGE DUE TO DEATH OR DIVORCE OF SPOUSE

If the Insured is no longer eligible for coverage due to the death of, or divorce from, the spouse, the Insured's coverage will continue in force under the Policy, subject to its provisions. If the Insured's premiums are being deducted from a payroll account, the Insured must remit the first quarterly premium for the continued coverage at the end of the period for which premium has already been paid or, if later, on the first Premium Due Date after We stop waiving premiums. All future premiums are due quarterly. The Insured must remit them directly to Us. We will consider requests for payment modes other than quarterly.
SGS6AA

EXTENSION OF BENEFITS

If the Insured's coverage under the Policy terminates, except as provided in (d) of the Individual Terminations provision, We will recognize the Insured's basis for a claim which started before the date of termination in the same manner as if the Insured's coverage were still in force. Extension of benefits stops on the earlier of:

(a) The end of a 6 month period during which no benefits become payable due to the same or a related condition; or

(b) The date the Lifetime Maximum Benefit is reached.
SGS7AA

CERTIFICATES

We will issue an individual certificate for the Insured. The certificate describes the benefits, to whom they are payable, the limits and where the Policy may be inspected.
SGS9AA

REINSTATEMENT OF COVERAGE

If the Insured's coverage terminates for non-payment of premium and if the Insured has a diagnosed organic brain disease or is Chronically Ill at the time of termination, We will reinstate coverage up to 5 months after the coverage terminated without requiring evidence of insurability. The reinstated coverage will cover losses from the date coverage terminates. All premium must be paid in order for coverage to be reinstated. Subsequent reinstatements may require evidence of insurability.

In all other situations, if the Insured's coverage terminates for non-payment of premium, coverage may be reinstated at Our option. We may require the Insured to submit an application for reinstatement. If We approve the application, coverage will be reinstated as of the date of Our approval. If We have accepted premium and issued a conditional premium receipt, the Insured's coverage will be reinstated no later than 45 days after the date of that receipt, unless We notify the Insured by written notice prior to that date that the application for reinstatement is not approved. If We do not require an application for reinstatement, coverage will be reinstated as of the date We accept the Insured's premium.

The reinstated coverage will cover only losses for conditions that start after the date of reinstatement. In all other aspects, the Insured's rights and Ours will be the same as before the coverage terminated, unless there are new provisions added due to the reinstatement. The premium We accept for reinstatement may be used for the period for which premiums were not paid. We can apply the premium back for as many as 60 days before the date of reinstatement.
SGS8EA-TQ

CLAIMS

Notice of Claim. Notice must be given to Us within 90 days after a loss. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice will be sufficient if it identifies the Insured and the Policy. It must be sent to Us at the following address:

Continental Casualty Company
PO Box 946760
Maitland, FL 32794-6760

SGC1BA

Claim Forms: After We receive the notice of claim, We will furnish any required forms within 15 days. If We do not, We will consider the Insured to have met the requirements for written proof of loss if We are given written proof of the extent and nature of the loss.
SGC2BA

Written Proof of Loss: Written or electronic proof of Eligible Expenses must be given to Us within 90 days after the date of such loss. If this is not reasonably possible, the claim is not affected if the proof is given to Us as soon as possible. Unless the Insured is legally incapacitated, written proof must be given within 1 year of the time it is otherwise due.
SGC3DA

Time of Payment of Claim: Benefits for a loss which requires periodic payment will be paid monthly subject to receipt of due written proof of loss. Any balance unpaid when liability terminates will be paid when We receive due written proof.
SGC4AA

Payment of Claim: All benefits are paid to the Insured or the Insured's estate, unless the Insured has assigned them elsewhere.

If benefits are payable to the estate, We may pay up to $1,000 to any relative of the Insured who We feel is entitled to them. Any payment We make in good faith discharges Us to the extent of the payment.
SGC5AA

Misstatement of Age: If the Insured's age has been misstated, the benefit will be in an amount that the premiums paid would have purchased at the Insured's true age. If coverage would not have been issued, We will refund the premium paid.
SGC6AA

Physical Examination and Assessment: At Our expense, We may, as often as reasonably necessary while the claim is pending, have a physician examine the Insured or obtain an assessment of the Insured's impairment.
SGC7AA-TQ

Claim Denial: If a claim is denied, We will make available to the Insured or the Insured’s personal physician, all information directly related to such denial. We will release such information within 60 days of Our receipt of the written request unless such disclosure is prohibited under state or federal law.
SGC9AA

Claim Appeal: If the Insured contests the denial, We will request from the Insured, the nature of the dispute in writing and (if applicable) the amount of money involved. We will then compile all relevant data including evaluations by qualified individuals independent of Us, if appropriate. The accumulated data will be reviewed by Us. The decision is sent to the Insured in writing within 60 days.
SGC10AA

PREMIUM

Payment of Premium: Premium is computed as stated in the Master Application. Premiums are payable in United States currency to Us on the Premium Due Dates stated in the Schedule.

We cannot change the Insured's premiums because of age or health. We can, however, change the Insured's premiums based on his or her premium class, but only if We change the premiums for all other Insureds in the same premium class. A change may be made, as provided in the following paragraph, on any Premium Due Date after the end of the Premium Rate Guarantee Period. The Premium Rate Guarantee Period starts on the Policy Effective Date. The length of this period is stated in the Schedule of the Master Application.

If We elect to change premium rates, the Insured's premiums change on his or her first Premium Due Date following the later of: (a) The effective date of the change stated in Our written notice to the Holder; or (b) the end of the Period for Notice of Premium Rate Changes stated in the Schedule of the Master Application. This period starts on the date the Holder receives the written notice from Us. If the Insured is paying premiums directly to Us, We will notify him or her of the change at least 31 days before the Premium Due Date on which his or her premiums change.

The Premium Rate Guarantee Period does not limit Our right not to renew the Policy, as stated in the Effective Date and Term provision.
SGP1AA

Grace Period: We allow a grace period of 31 days for each premium due after the first premium. The Insured's coverage stays in force during the grace period. It terminates at the end of the grace period of an unpaid premium, unless non-payment is due to a clerical error made by Us or the Holder.
SGP2AA

Refund of Unearned Premium at Death: If the Insured dies, We will make a pro-rata refund of premium paid for the period beyond the date of death.
SGP3AA

Unintentional Lapse: The Insured has the right to designate another individual to receive notification of lapse. Upon notice of nonpayment of premium, We will inform both the Insured and, if chosen, the designated individual at least 30 days before the effective date of lapse. If payment is through a payroll or pension deduction plan, We will inform both the Insured and, if chosen, the designated individual 60 days after the Insured is no longer on a payroll or pension deduction plan. The notice will be given by first class United States mail, postage prepaid, to the designated individual no earlier than 30 days after the premium due date. Notice is considered to have been given as of 5 days after the date of mailing. The Insured will be notified of the right to change the designated person at least once every 2 years.
SGP6AB

THE CONTRACT

Entire Contract; Changes: The Policy, the Master Application, the individual applications of the Insureds and any attached papers make up the entire contract between the parties. No change is valid unless approved in writing on the Policy by one of Our officers. No agent may change the Policy or waive any of its provisions.
SGX1AA

Incontestability: Statements the Holder or the Insured makes are, in the absence of fraud, representations and not warranties. No statement voids the insurance, reduces the benefits or may be used in defense to a claim unless it is in writing and a copy of it has been furnished to the Holder or the Insured, whoever made the statement.

After the Insured’s coverage has been in force for 2 years, only fraudulent misstatements of the Insured may be used to void the Insured’s coverage. After the Insured’s coverage has been in force for at least 6

months but less than 2 years, only misstatements of the Insured on the application and which pertains to the condition for which benefits are sought may void the Insured's coverage. If the Insured's coverage has been in force for less than 6 months, any misstatements of the Insured may be used to void the Insured's coverage in the event that We would not have issued coverage if the correct information was known.

After the Policy has been in force for 2 years, only fraudulent misstatements of the Holder may be used to void the Policy.
SGX2AC-TQ

Legal Actions: No action at law or in equity may be brought until 60 days after the date written proof of loss was given. No action may be brought after 3 years from the date written proof is required.
SGX3AA

Conformity with Statutes: If a provision conflicts with the statutes of the jurisdiction in which the Policy was delivered or issued, it is automatically changed to meet the minimum requirements of the statute.
SGX4AA

TEMPORARY BED HOLDING BENEFIT

When the Insured is receiving benefit payments for Nursing Home Care, We will pay the Temporary Bed Holding Benefit, subject to the conditions below, if the Insured is temporarily absent from the Nursing Home due to a hospital stay or other event. The Temporary Bed Holding Benefit will be paid only if the Insured continues to incur a charge for a bed in the Nursing Home and that charge would have been assessed even in the absence of insurance.

(a) The benefit will equal the Long Term Care Benefit payable for Nursing Home Care. It will be limited to 21 days per calendar year. Unused days cannot be carried over into the next calendar year.

(b) The temporary absence must start while the Insured is receiving benefits for Nursing Home Care.

(c) The Lifetime Maximum Benefit must not yet have been reached.
SGB1AA

CAREGIVER TRAINING BENEFIT

Caregiver Training means training received by the Informal Caregiver to care for the Insured in the Insured's Residence.

Informal Care means Informal Care provided by an Informal Caregiver, making it unnecessary for the Insured to be in a Nursing Home, or to receive such care in the Insured's Residence from a paid provider.

Informal Caregiver means the person who has the primary responsibility of caring for the Insured in the Insured's Residence. A person who is paid for caring for the Insured cannot be an Informal Caregiver.

BENEFIT

We will pay the Caregiver Training Benefit stated in the Schedule, subject to the conditions below:

(a) The conditions which must be met for the Long Term Care Benefit to become payable, stated in the Long Term Care Benefit provision, must also be met for benefits to become payable under this provision. However, there is no Waiting Period.

(b) The Caregiver Training must be provided by a Home Health Care Provider, Nursing Home or hospital while the Insured is receiving Long Term Care or Informal Care. If the Insured is in a Nursing Home or in a hospital, the Caregiver Training Benefit will only be payable if the training will make it possible for the Insured to return to the Insured's Residence where he or she can be cared for by the Informal Caregiver.

(c) If Long Term Care or Informal Care due to the same or a related condition stops, the Caregiver Training Benefit will again become payable subject to the preceding conditions if Long Term Care or Informal Care resumes due to a new or unrelated condition. We will consider Long Term Care or Informal Care due to the same or a related condition to have stopped when 6 months have passed during which the Insured has received no Long Term Care or Informal Care due to such condition.

SGT1AA

EMERGENCY ALERT SYSTEM BENEFIT

Emergency Alert System is a communication system located in the Insured's Residence which is used to summon medical attention in case of a medical emergency.

We will pay the Emergency Alert System Benefit stated in the Schedule for the rental or lease of an Emergency Alert System for the Insured's Residence while the Insured is living in that residence, subject to the conditions below.

(a) We will start paying the Emergency Alert System Benefit when benefits for Community Based Care start. The Emergency Alert System Benefit will continue to be paid until 6 months pass during which the Insured receives no Community Based Care, or, if earlier, until Nursing Home Care starts.

(b) The Insured's condition must be such that he or she could not be left alone were it not for the presence of the Emergency Alert System.

(c) We will not pay for any charges for normal telephone service while the system is installed or for a home security system.

(d) The Lifetime Maximum Benefit must not yet have been reached.

SGM1AA

CAREGIVER BENEFIT

SGIN1AA

We will pay the Caregiver Benefit stated in the Schedule, subject to the conditions below:

1. The conditions which must be met for the Long Term Care Benefit to become payable, stated in the Long Term Care Benefit provision, must also be met for benefits to become payable under this provision.

SGIN2AA

2. The Waiting Period stated in the Schedule must be met. The Waiting Period for Informal Care begins on the day We receive written notice of claim at Our Home Office.

SGIN3AA

3. The Insured must have been certified by a Licensed Healthcare Practitioner as being Chronically Ill and have been receiving care from the Informal Caregiver during the entire Waiting Period.

4. The Insured may not receive benefits under this provision while receiving the Long Term Care Benefit payable for Nursing Home Care. The Insured may receive Community Based Care in conjunction with Informal Care. In this event, We will pay the Long Term Care Benefit payable for Community Based Care, subject to the provisions of the Policy, in addition to the Caregiver Benefit. In no event will the total amount of benefits received under the Policy exceed the Long Term Care benefit payable for Nursing Home Care stated in the Schedule.

SGIN4AA-TQ

HOSPICE CARE FACILITY BENEFIT

We will pay the Hospice Care Facility Benefit stated in the Schedule, subject to the conditions below:

(a) The conditions which must be met for the Long Term Care Benefit to become payable, stated in the Long Term Care Benefit provision, must also be met for benefits to become payable under this provision;

(b) Care must be received in a facility that specializes in Hospice Care for patients who are expected to live less than six months. This facility is a stand-alone facility or ward/wing of a Nursing Home and is licensed by the state in which it is located;

(c) The benefit payable for Hospice Care in a Hospice Care Facility will equal the Long Term Care Benefit payable for Nursing Home Care. However, benefits will not be paid for Hospice Care in a Hospice Care Facility, Community Based Care and Nursing Home Care simultaneously; and

(d) The Lifetime Maximum Benefit must not yet have been met.

SGHC1AA

BENEFIT ACCOUNT

If the Insured has had at least 3 years of continuous coverage under the Policy, and this benefit has been in effect for at least three years, then, at the end of the grace period of an unpaid premium, the Insured's coverage will be continued in force with the same daily benefit but a reduced Lifetime Maximum Benefit, with no further premiums being payable.

The reduced Lifetime Maximum Benefit will equal the total premiums paid toward a plan which includes this benefit. However, the reduced Lifetime Maximum Benefit will never be less than 30 times the Insured's daily benefit.

The reduced Lifetime Maximum Benefit will not be reduced due to prior benefits paid under the Policy but, in no case will the total benefits paid under the Policy exceed what would have been paid had the Insured continued to pay premiums.

No benefit increases will be offered after the effective date of the reduced benefit.

If the Insured has the Automatic Benefit Increase provision, no further increases under that provision will occur after the effective date of the reduced benefit.

The reduced Lifetime Maximum Benefit will take effect on the Premium Due Date of the unpaid premium or, if later, on the date Extension of Benefits stops.

The reduced Lifetime Maximum Benefit will be subject to the provisions of the Policy.

SGF1JB

GUARANTEED BENEFIT INCREASE OPTION

On the third anniversary of the Policy Effective Date and no less than every three years thereafter, the Insured may elect to increase each benefit amount then in effect by the amount stated in the Schedule.

If the Insured elects to increase coverage, the premium for the increase in coverage will be based on the Insured’s attained age at the time of the increase. The premium for the increase in coverage will be added to the premium being charged for the Insured’s previous amount of coverage.

The Insured has the right to accept the benefit increase offers without showing evidence of insurability as long as the Insured increased his benefit amount at the most recent previous benefit increase offer. When an offer is declined, the Insured must submit evidence of insurability in order to exercise the next benefit increase offer. Once We accept the Insured’s evidence of insurability, We will not require further evidence of insurability for future benefit increase offers until another offer is declined.

SGI1GC

Continental Casualty Company

CNA
For All the Commitments You Make®

CNA Plaza A Stock Company

Chicago, Illinois 60685

ADMINISTRATIVE RIDER

It is understood and agreed that in the event the Group Long Term Care policy to which this rider is attached replaces another Long Term Care policy, the Continental Casualty Company will waive any time periods applicable to pre-existing conditions, waiting periods and waiver of premium qualification periods to the extent such time was spent under the policy being replaced.

Signed for the Continental Casualty Company at its Home Office, CNA Plaza, Chicago, Illinois 60685.

Bernard L. Hengesbaugh

Chairman of the Board

SRAR-11

Continental Casualty Company

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CNA Plaza A Stock Company

Chicago, Illinois 60685

ADMINISTRATIVE RIDER

This amendment is part of the Policy. It is understood and agreed that the Guaranteed Benefit Increase Option has been amended as follows:

Employees who are actively-at-work and their spouses may refuse any number of benefit increase offers without forfeiting the right to accept future offers on a guarantee issue basis.

SR-15288 (GBO)

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Chicago, Illinois 60685

ADMINISTRATIVE RIDER

TRANSFER OF FUNDS UPON TERMINATION OF POLICY

In the event an employer terminates their policy with Continental Casualty Company, we will offer all Insureds the option of continuing coverage with Continental Casualty Company, as required by law. We will transfer policy reserves for those who elect coverage under an equivalent new long term care program sponsored by the employer that charges premiums based on the Insured's age at enrollment in Continental Casualty Company's program.

The amount of reserves transferred shall equal (a) minus (b), summed over all Insureds who elect to transfer to the new carrier.

(a) Equals the net level benefit reserve based on the actuarial assumptions at original issue of the certificate. For incremental plan changes, such as purchase of additional coverage amounts, we will establish the reserve for each additional coverage amount based on the assumptions in effect at the time of the purchase of the additional coverage.

(b) Equals the unamortized acquisition expense, based on the actuarial assumptions at original issue of the certificate. For incremental plan changes, such as purchase of additional coverage amounts, we will calculate the unamortized acquisition expense for each additional coverage amount based on the assumptions in effect at the time of the purchase of the additional coverage

If records are passed to the succeeding insurer using Continental Casualty Company's standard formats, there will be no deduction from the reserve amount for expenses incurred in transferring the records. However if special record formats or additional information is needed, the actual cost to develop such special formats and information will be deducted from the amount otherwise transferred.

SPAR-012803

ERISA INFORMATION

NAME OF THE PLAN

Westinghouse Government Services Group Welfare Benefits Plan

NAME AND ADDRESS OF EMPLOYER

Westinghouse Government Services Group
4350 Northern Pike, Room 217C
Monroeville, PA 15146-2886

EMPLOYER IDENTIFICATION NUMBER AND PLAN NUMBER

82-0508469

TYPE OF ADMINISTRATION

The Plan is insured by Continental Casualty Company.

PLAN ADMINISTRATOR NAME, BUSINESS ADDRESS AND PHONE NUMBER

The Administrative Committee
4350 Northern Pike, Room 217C
Monroeville, PA 15146-2886
(412) 374-3995

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made to the designated Agent at the following Address:

The Administrative Committee
4350 Northern Pike, Room 217C
Monroeville, PA 15146-2886

For disputes arising under those portions of the Plan insured by Continental Casualty Company, service of legal process may be made upon Continental Casualty Company at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

CONTRIBUTIONS

You must pay the insurance premiums for long term care benefits to be eligible for such benefits.

PLAN YEAR

The Plan's fiscal records are kept on a plan year basis beginning each January 1st and ending on the following December 31st.

CLAIMS INFORMATION

Routine Questions

If there is any question about a claim payment for long term care, you should contact Continental Casualty Company.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for an entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

STATEMENT OF ERISA RIGHTS

As a participant in the Westinghouse Government Services Group Welfare Benefits Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain copies of all documents governing the operation of the Plan and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of the documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part (and you have exhausted the Plan's internal appeal procedure), you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

* * * *

FUTURE OF THE PLAN

Westinghouse presently intends to continue long term care coverage for employees. However, Westinghouse has the right to amend or terminate long term care coverage provisions of the Plan. Any amendment which terminates long term care coverage under the Westinghouse Government Services Group Welfare Benefits Plan must be approved by the Westinghouse Board of Directors. Long term care coverage under the Westinghouse Government Services Group Welfare Benefits Plan is not vested. Westinghouse's right to change the Plan may be exercised by the Company's Director of Human Resources or Chief Financial Officer by appropriate written action, and, with respect to changes that do not materially increase costs or materially change participants' benefits, may be exercised by the Company's Director, Compensation and Benefits, by appropriate written action. Westinghouse's Board of Directors must approve any amendment that terminates the Plan.

*

Appendix P – HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how the medical, dental, vision, Employee Assistance Program and Health Care Spending Account components of the Westinghouse Government Services Group Welfare Benefits Plan (referred to in this Notice as "the Plan") may use and disclose your protected health information, and describes your rights with respect to such information. Your "protected health information" includes your individually identifiable information that is created or received by the Plan, that relates to: (i) your past, present or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present or future payment for the provision of health care to you.

**The Plan is required by law to maintain the privacy of your protected health information and is required to provide you with a copy of this notice under regulations implementing the Health Insurance Portability and Accountability Act ("HIPAA"). ** This Notice sets forth the Plan's legal duties and its privacy practices with respect to your protected health information, and describes your rights to access and control your protected health information. The Plan must abide by the terms of this Notice. This Notice has been drafted in accordance with the HIPAA Privacy Rule, which is contained in the Code of Federal Regulations at 45 CFR Parts 160 and 164. Any terms that are not defined in this Notice have the same meaning as they have in the HIPAA Privacy Rule. The HIPAA Privacy Rule supercedes any discrepancy between the information in this notice and the HIPAA Privacy Rule.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The Plan will not disclose your protected health information unless it is permitted or required to do so. The Plan may use and disclose protected health information for the Plan's purpose of providing you with coverage under the health care components of the Plan. The main reason that the Plan will use and disclose your protected health information will be to evaluate and process any request for coverage and claims for benefits under the Plan. The Plan will not, however, disclose your protected health information to any other entity for their use in marketing products to you. This section describes these and other uses of your protected health information, together with some examples. The Plan may disclose your protected health information without your authorization for the purposes described in this section, except that: (i) your authorization to disclose your protected health information may be required as described under the last two items in this section; and (ii) you may request a restriction on the disclosure of your protected health information as described in the third-to-last item described in this section.

Payment and Health Care Operations. The Plan has the right to use and disclose your protected health information for all activities that are included within the definitions of "payment" and "health care operations" in the HIPAA Privacy Rule.

> *Payment.* The Plan will use or disclose your protected health information to fulfill its responsibilities for providing coverage and processing benefit claims under the Plan. For example, the Plan may disclose your protected health information when a provider requests information regarding your eligibility for benefits under the Plan, or it may use your information to determine if a treatment that you received was medically necessary.
>
> *Health Care Operations*. The Plan will use or disclose your protected health information to support the Plan's related functions. These functions include, but are not limited to: quality assessment and improvement, reviewing provider performance, case management, and auditing. For example, the Plan may use or disclose your protected health information: (i) to provide you

with information about a disease management program; (ii) to respond to a customer service inquiry from you; (iii) in connection with fraud and abuse detection and compliance programs, or (iv) to survey you concerning how effectively the Plan is providing services, among other issues.

Business Associates. The Plan contracts with service providers – called business associates – to perform various functions on its behalf. For example, the Plan may contract with a service provider to perform the administrative functions necessary to pay your medical claims. To perform these functions or to provide the services, business associates will receive, create, maintain, use, or disclose protected health information, but only after the Plan and the business associate agree in writing to contract terms requiring the business associate to appropriately safeguard your information.

Other Covered Entities. The Plan may use or disclose your protected health information to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with certain health care operations. For example, the Plan may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and the Plan may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing, or credentialing. This also means that the Plan may disclose or share your protected health information with other health care programs or insurance carriers (such as Medicare) in order to coordinate benefits, if you or your family members have other health insurance or coverage.

Required by Law. The Plan may use or disclose your protected health information to the extent required by federal, state, or local law.

Public Health Activities. The Plan may use or disclose your protected health information for public health activities that are permitted or required by law. For example, it may use or disclose information for the purpose of preventing or controlling a communicable disease.

Health Oversight Activities. The Plan may disclose your protected health information to a health oversight agency for activities authorized by law. For example, these oversight activities may include audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and government agencies that ensure compliance with civil rights laws.

Lawsuits and Other Legal Proceedings. The Plan may disclose your protected health information in the course of any judicial or administrative proceeding or in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized by such order). If certain conditions are met, the Plan may also disclose your protected health information in response to a subpoena, a discovery request, or other lawful process.

Abuse or Neglect. The Plan may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, if the Plan believes you have been a victim of abuse, neglect, or domestic violence, it may disclose your protected health information to a governmental entity authorized to receive such information.

Law Enforcement. Under certain conditions, the Plan also may disclose your protected health information to law enforcement officials for law enforcement purposes. These law enforcement purposes include, for example, (1) responding to a court order or similar process; (2) locating or identifying a suspect, fugitive, material witness, or missing person; or (3) providing information relating to the victim of a crime.

Coroners, Medical Examiners, and Funeral Directors. The Plan may disclose protected health information to a coroner or medical examiner when necessary for identifying a deceased person or determining a cause of death, or for such other duties as authorized by law. The Plan also may disclose

protected health information to funeral directors as necessary to carry out their duties with respect to the decedent.

Organ and Tissue Donation. The Plan may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

Research. The Plan may disclose your protected health information to researchers when (1) their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information, or (2) the research involves a limited data set which includes no unique identifiers (*i.e.*, information such as name, address, social security number, *etc.*, that can identify you).

To Prevent a Serious Threat to Health or Safety. Consistent with applicable laws, the Plan may disclose your protected health information if disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. It also may disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military. Under certain conditions, the Plan may disclose your protected health information for activities deemed necessary by appropriate military command authorities if you are or were in the Armed Forces. If you are a member of a foreign military service, the Plan may, in certain circumstances, disclose your information to the foreign military authority.

National Security and Protective Services. The Plan may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety, and the health and safety of others; or (3) the safety and security of the correctional institution.

Workers' Compensation. The Plan may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

Disclosures to the Secretary of the U.S. Department of Health and Human Services. The Plan is required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Disclosures to Others Involved in Your Health Care. The Plan may disclose your protected health information to a friend or family member that is involved in your health care, unless you request a restriction in accordance with the process described below under "Right to Request Restrictions." The Plan also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your protected health information, then the Plan may determine whether the disclosure is in your best interest. To protect those who depend on others to exercise their rights under the HIPAA Privacy Rules, the Plan may, in certain circumstances, deny a friend or family member that is involved in your health care access to your protected health information.

Disclosures of Psychotherapy Notes. To the extent that the Plan receives any psychotherapy notes about you, your written authorization must be provided before the Plan will use or disclose such psychotherapy notes. Psychotherapy notes are separately-filed notes about your conversation with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may, however, use and disclose such psychotherapy notes when needed by the Plan to defend against litigation filed by you.

Disclosures to You. The Plan is required to disclose to you or your personal representative most of your protected health information when you request access to this information. The Plan will disclose your protected health information to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant law. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your protected health information or allowed to take any action for you. Proof of such authority may take any of the following forms, or such other form as the Plan determines is appropriate under the circumstances: (1) the person provides a power of attorney for health care purposes that is notarized by a notary public; or (2) the person provides a court order appointing himself or herself as your conservator or guardian. A person who is the parent or legal guardian of a minor child or legally-incompetent child will be deemed to have authority to access the child's protected health information and to take any action for such child. The Plan may elect not to treat the person as your personal representative if it has a reasonable belief that you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; treating such person as your personal representative could endanger you; or the Plan determines that it is not in your best interest to treat the person as your personal representative.

DISCLOSURES TO THE PLAN SPONSOR

The Plan may disclose your protected health information to the plan sponsor. For example, the Plan may inform the plan sponsor that you are enrolled in the Plan because the plan sponsor performs some of the administrative functions necessary for the management and operation of the Plan, such as withholding the employee's share of premiums from an employee's paycheck for any employee enrolled in the Plan. In addition, the Plan may disclose summary health information in the form of a limited data set (that is, a list of information that summarizes claims history, claims expenses or types of claims without identifying you) to the plan sponsor for purposes of health care operations, such as for the purpose of conducting cost-management and planning-related analyses related to managing and operating the Plan.

OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Any other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. For example, if you ask your local human resources representative and/or advocacy service to assist you in obtaining benefits under the Plan, you must complete and sign an authorization and give it to your local human resources representative and/or advocacy service before the Plan will disclose your protected health information to the human resources representative and/or advocacy service; if you do not sign an authorization in this situation, the Plan will not be able to disclose any of your protected health information to the human resources representative and/or advocacy service and, therefore, the human resources representative and/or advocacy service may not be able to provide you with effective assistance. If you provide the Plan with an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that the Plan has used or disclosed in reliance on the authorization.

CONTACTING YOU

The Plan (or its health insurance issuers or third-party administrators) may contact you about treatment alternatives or other health benefits or services that might be of interest to you.

YOUR RIGHTS

The following is a description of each individual's rights with respect to his or her protected health information. Each and every employee, retiree, spouse, and child who is over the age of majority and who is covered by the Plan has an independent right to exercise the rights described in this section.

Right to Request a Restriction. You have the right to request a restriction on the protected health information the Plan uses or discloses about you for payment or health care operations. You also have a right to request a limit on disclosures of your protected health information to family members or friends who are involved in your care or the payment for your care. If you want to request such a restriction, ***your request must be submitted in writing*** using the Contact Information at the end of this Notice. **While the Plan will consider your request, the Plan is not required to agree to any restriction that you request.** In addition, the Plan will not agree to restrictions on the use or disclosure of protected health information if such use or disclosure is legally required, or is necessary to administer the Plan. If the Plan agrees to the restriction on the use or disclosure of your protected health information, it can stop complying with the restriction upon providing notice to you. Your request must describe (i) the protected health information you wish to limit, (ii) whether you want to limit the Plan's use, disclosure, or both, and (iii) if applicable, to whom you want the limitations to apply (for example, restricting disclosures to your spouse).

Right to Request Confidential Communications. If you believe that a disclosure of all or part of your protected health information may endanger you, you may request that the Plan communicate with you in an alternative manner or at an alternative location. For example, you may ask that all communications be sent to your work address. If you request confidential communications, ***your request must be submitted in writing*** using the Contact Information at the end of this Notice. Your request must specify the alternative means or location for communication with you. It also must state that the disclosure of all or part of the protected health information in a manner inconsistent with your instructions would put you in danger. The Plan will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your protected health information could endanger you.

Right to Request Access. You or your personal representative has the right to inspect and copy your protected health information in a "Designated Record Set" if you believe that information is incorrect or incomplete. A "Designated Record Set" includes enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan. Information that is used for quality control or peer review analyses, that is not used to make decisions about an individual, is not included as part of the Designated Record Set. If you want to inspect and/or copy this information, ***your request must be submitted in writing*** using the Contact Information at the end of this Notice.

Please note that, under federal law, you may not inspect or copy the following records that are created or received by the Plan: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

Your written request to inspect and copy your protected health information should be addressed to the person listed in the Contact Information at the end of this Notice. If you request copies, the Plan will charge you 15¢ per page to copy your protected health information, as well as postage if you request that copies be mailed to you or your personal representative.

If you request access to protected health information and that access is denied, in some, but not all, circumstances, you may have a right to have the decision to deny access reviewed. The review will be conducted by an individual chosen by a representative of the Plan who was not involved in the decision to deny your request to access the information.

Right to Request an Amendment. You have the right to request an amendment of your protected health information held by the Plan in a Designated Record Set. If you request an amendment of your protected health information, ***your request must be submitted in writing*** using the Contact Information at the end of this Notice, and must set forth one or more reasons in support of the proposed amendment.

The Plan has 60 days after your request to amend your protected health information to act on the request, except that an additional 30-day period is allowed if the Plan is unable to comply with your request within the initial 60-day period and the Plan gives you a written statement of the reasons for the delay and the date by which the Plan will make a decision on your request.

In certain cases, the Plan may deny your request for an amendment. For example, the Plan may deny your request if the information you want to amend is accurate and complete or was not created by the Plan. If the Plan denies your request, you have the right to file a statement of disagreement. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

Right to Request an Accounting. You have the right to request an accounting of certain disclosures the Plan has made of your protected health information. The list of disclosures will **not** include, among other disclosures, disclosures made for treatment, payment, health care operations, for purposes of national security, to law enforcement or to corrections personnel, pursuant to your authorization or directly to you. If you request an accounting, ***your request must be submitted in writing*** using the Contact Information at the end of this Notice. You can request an accounting of disclosures made up to six years prior to the date of your request, except that the Plan is not required to account for disclosures made prior to April 14, 2003. Your request must state the time period from which you want to receive a list of disclosures. You are entitled to one accounting free of charge during a twelve-month period. There will be a charge to cover the Plan's costs for additional requests within that twelve-month period. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred. The Plan has 60 days after your request for an accounting to act on the request, except that an additional 30-day period is allowed if the Plan is unable to comply with your request within the initial 60-day period and the Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

Right to a Paper Copy of This Notice. If you have received this notice electronically, you have the right to a paper copy of this Notice. The simplest way to obtain a paper copy of this Notice is to print a copy of this Notice on your local or network printer. You may also obtain a paper copy of this notice by contacting Mary Iorio, Westinghouse Electric Company, 4350 Northern Pike, Monroeville, PA 15146, 412-374-3995.

COMPLAINTS

If you believe the Plan has violated your privacy rights, you may complain to the Plan or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with the Plan using the Contact Information at the end of this Notice. The Plan will not penalize you for filing a complaint.

CHANGES TO THIS NOTICE

The Plan reserves the right to change the provisions of this Notice and make the new provisions effective for all protected health information that it maintains. If the Plan makes a material change to this Notice, it will provide a revised Notice to you (i) by e-mail if you are a current employee of Westinghouse Government Services Group, or (ii) if you are not a current employee, at the address that the Plan has on record for you.

EFFECTIVE DATE

This Notice of Privacy Practices is effective on April 14, 2003.

CONTACT INFORMATION

If you (i) have any questions or want additional information about this Notice, the policies and procedures described in the Notice, (ii) want to exercise any of the rights described in this Notice, or (iii) file a complaint, please contact:

James A. Buddie

Westinghouse Electric Company

4350 Northern Pike

Monroeville, PA 15146

412-374-3995